DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

Office of Inspector General

42 CFR Parts 409, 410, 411, 412, 413, 419, 489, 498, and 1003

[HCFA–1005–P]

RIN 0938–AI56

Medicare Program; Prospective Payment System for Hospital Outpatient Services

AGENCY: Health Care Financing Administration (HCFA), HHS, and Office of Inspector General (OIG), HHS.

ACTION: Proposed rule.

SUMMARY: As required by sections 4521, 4522, and 4523 of the Balanced Budget Act of 1997, this proposed rule would eliminate the formula-driven overpayment for certain outpatient hospital services, extend reductions in payment for costs of hospital outpatient services, and establish in regulations a prospective payment system for hospital outpatient services (and for Medicare Part B services furnished to inpatients who have no Part A coverage). The prospective payment system would simplify our current payment system and apply to all hospitals, including those that are excluded from the inpatient prospective payment system. The Balanced Budget Act provides for implementation of the prospective payment system effective January 1, 1999, but delays application of the system to cancer hospitals until January 1, 2000. The hospital outpatient prospective payment system would also apply to partial hospitalization services furnished by community mental health centers.

Although the statutory effective date for the outpatient prospective payment system is January 1, 1999, implementation of the new system will have to be delayed because of year 2000 systems concerns. The demands on intermediary bill processing systems and HCFA internal systems to become compliant for the year 2000 preclude making the major systems changes that are required to implement the prospective payment system. The outpatient prospective payment system will be implemented for all hospitals and community mental health centers as soon as possible after January 1, 2000, and a notice of the anticipated implementation date will be published in the **Federal Register** at least 90 days in advance.

This document also proposes new requirements for provider departments and provider-based entities. These proposed changes, as revised based on our consideration of public comments, will be effective 30 days after publication of a final rule.

This proposed rule would also implement section 9343(c) of the Omnibus Budget Reconciliation Act of 1986, which prohibits Medicare payment for nonphysician services furnished to a hospital outpatient by a provider or supplier other than a hospital, unless the services are furnished under an arrangement with the hospital. This section also authorizes the Department of Health and Human Services' Office of Inspector General to impose a civil money penalty, not to exceed $10,000, against any individual or entity who knowingly and willfully presents a bill for non-physician or other bundled services not provided directly or under such an arrangement.

This proposed rule also addresses the requirements for designating certain entities as provider-based or as a department of a hospital.

DATES: Comments will be considered if we receive them at the appropriate address, as provided below, no later than 5 p.m. on November 9, 1998.

ADDRESSES: Mail written comments (1 original and 3 copies) to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA–1005–P, P.O. Box 26688, Baltimore, MD 21207–0488.

If you prefer, you may deliver your written comments (1 original and 3 copies) to one of the following addresses:

Room 309–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or

Room C5–09–26, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code HCFA–1005–P. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, in Room 309–G of the Department's offices at 200 Independence Avenue, SW., Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: (202) 690–7890).

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FOR FURTHER INFORMATION CONTACT:

Janet Wellham, (410) 786–4510 (for general information). Joel Schaer (OIG), (202) 619–0089 (for information concerning civil money penalties).

Kitty Ahern, (410) 786–4515 (for information related to the classification of services into ambulatory payment classification (APC) groups).

Suzanne Letsch (410) 786–4558 (for information related to volume control measures and updates).

George Morey (410) 786–4653 (for information related to the determination of provider-based status).

Janet Samen (410) 786–9161 (for information on the application of APCs to community mental health centers).

SUPPLEMENTARY INFORMATION: To assist readers in referencing sections contained in this document, we are providing the following table of contents.

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In addition, because there are many terms to which we refer by acronym in this rule, we are listing these acronyms and their corresponding terms in alphabetical order below:

APC Ambulatory payment classification
APG Ambulatory patient group
ASC Ambulatory surgical center
BBA Balanced Budget Act of 1997
CAH Critical access hospital
CCI [HCFA's] Correct Coding Initiative
CCR Cost center specific cost-to-charge ratio
CHAMPUS Civilian Health and Medical Program of the Uniformed Services
CMHC Community mental health center
CMP Civil money penalty
CORF Comprehensive outpatient rehabilitation facility
CPT [Physicians'] Current Procedural Terminology, 4th Edition, 1998, copyrighted by the American Medical Association
DME Durable medical equipment
DMEPOS DME, orthotics, prosthetics, prosthetic devices, prosthetic implants and supplies
DRG Diagnosis-related group
EACH Essential access community hospital
ESRD End-stage renal disease
FDO Formula-driven overpayment
FQHC Federally qualified health center
HCPCS HCFA Common Procedure Coding System
HHA Home health agency
ICD–9–CM International Classification of Diseases, Ninth Edition, Clinical Modification
IME Indirect medical education
IOL Intraocular lens
MDC Major diagnostic category
MDH Medicare dependent hospital
MedPAC Medicare Payment Advisory Commission
MSA Metropolitan statistical area
NECMA New England County Metropolitan Area
OBRA Omnibus Budget Reconciliation Act
PPS Prospective payment system
RHC Rural health clinic
RPCH Rural primary care hospital
RRC Rural referral center
SCH Sole community hospital
SGR Sustainable growth rate
SNF Skilled nursing facility
TEFRA Tax Equity and Fiscal Responsibility Act of 1982

I. Background

As the Medicare statute was originally enacted, Medicare payment for hospital services (inpatient and outpatient) was based on hospital-specific reasonable costs attributable to serving Medicare beneficiaries. Later, the law was amended to limit payment to the lesser of a hospital's reasonable costs or to its customary charges. In 1983, section 601 of the Social Security Amendments of 1983 (Public Law 98–21) completely revised the cost-based payment system for most hospital inpatient services by enacting section 1886(d) of the Social

Security Act (the Act). This section provided for a prospective payment system (PPS) for acute inpatient hospital stays, effective with hospital cost reporting periods beginning on or after October 1, 1983.

Although payment for most inpatient services became subject to a PPS, hospital outpatient services continued to be paid based on hospital-specific costs, which provided little incentive for hospital efficiency for outpatient services. At the same time, advances in medical technology and changes in practice patterns were bringing about a shift in the site of medical care from the inpatient to the outpatient setting. During the 1980s, the Congress took steps to control the escalating costs of providing outpatient care. The Congress amended the statute to implement across-the-board reductions of 5.8 percent and 10 percent to the amounts otherwise payable for hospital operating costs and capital costs, respectively, and legislated a number of different payment methods for specific types of hospital outpatient services. These methods included fee schedules for clinical diagnostic laboratory tests, orthotics, prosthetics, and durable medical equipment (DME); composite rate payment for dialysis for persons with end-stage renal disease (ESRD); and payments based on blends of hospital costs and the rates paid in other ambulatory settings such as separately certified ambulatory surgical centers (ASCs) or physician offices for certain surgery, radiology, and other diagnostic procedures. Nevertheless, Medicare payment for services performed in the hospital outpatient setting remains largely cost-based.

In section 9343(f) of the Omnibus Budget Reconciliation Act of 1986 (OBRA 1986) (Public Law 99–509) and in section 4151(b)(2) of the Omnibus Budget Reconciliation Act of 1990 (Public Law 101–508), the Congress required the Secretary to develop a proposal to replace the current hospital outpatient payment system with a PPS and to submit a report to the Congress on the proposed system. In OBRA 1986, the Congress paved the way for development of a PPS, under section 9343(g), by requiring fiscal intermediaries to require hospitals to report claims for services under the HCFA Common Procedure Coding System (HCPCS), and, under section 9343(c), by extending the prohibition against unbundling of hospital services under section 1862(a)(14) of the Act to include outpatient services as well as inpatient services. HCPCS coding enabled us to determine what specific procedures and services were being billed, while the extension of the prohibition against unbundling ensured that all nonpractitioner services provided to hospital outpatients would be billed only by the hospital, not by an outside supplier, and, therefore, would be reported on hospital bills and captured in the hospital outpatient data that could be used to develop an outpatient PPS.

Section 1866(g) of the Act, as added by section 9343(c) of OBRA 1986, and amended by section 4085(i)(17) of the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) (Public Law 100–203), also authorizes the Department of Health and Human Services' Office of Inspector General to impose a civil money penalty (CMP), not to exceed $2,000, against any individual or entity who knowingly and willfully presents a bill in violation of an arrangement (as defined in section 1861(w)(1) of the Act).

A proposed rule to implement section 9343(c) was published in the **Federal Register** on August 5, 1988. However, those regulations were never published as a final rule, so we are including them in this regulation and will implement them as part of the final regulation implementing the hospital outpatient PPS.

The Secretary submitted a Report to Congress on March 17, 1995. The report summarized the research HCFA conducted in searching for a way to classify outpatient services for purposes of developing an outpatient PPS. The report cited Ambulatory Patient Groups (APGs), developed by 3M-Health Information Systems under a cooperative grant with HCFA, as the most promising classification system for grouping outpatient services and recommended that APG-like groups be used in designing a hospital outpatient PPS.

The report also presented a number of options that could be used, once a PPS was in place, for addressing the issue of rapidly growing beneficiary copayment. As a separate issue, we recommended that the Congress amend the provisions of the law pertaining to the blended payment methods for ASC surgery, radiology, and other diagnostic services to correct an anomaly that resulted in a less than full recognition of the amount paid by the beneficiary in calculating program payment (referred to as the formula-driven overpayment).

The Balanced Budget Act of 1997 (BBA) (Public Law 105–33), enacted on August 5, 1997, contains a number of provisions that affect Medicare payment for hospital outpatient services. The purpose of this proposed rule is to implement sections 4521, 4522, and 4523 of the BBA and section 9343(c) of OBRA 1986. Section 4521 of the BBA eliminates the formula-driven overpayment effective for services furnished on or after October 1, 1997. Because of the October 1, 1997 effective date, HCFA has already taken action to implement this provision. Section 4522 extends the current cost reductions of 5.8 percent and 10 percent (applicable to hospital outpatient operating costs and hospital capital costs, respectively) through and including December 31, 1999.

Section 4523 of the BBA amends section 1833 of the Act by adding subsection (t), which provides for implementation of a PPS for most hospitals for outpatient services furnished on or after January 1, 1999 and for cancer hospitals that are excluded from inpatient PPS for services furnished on or after January 1, 2000. We note that while the statutory effective date for the outpatient PPS is January 1, 1999, implementation of the new payment system will have to be delayed because of year 2000 systems concerns. The demands on intermediary bill processing systems and HCFA internal systems to become compliant for the year 2000 preclude making the major systems changes that are required to implement the PPS. See Section XI of this preamble (''Delay in Implementation'') for a more detailed explanation of the reasons for delay. The outpatient PPS will be implemented as soon as possible after January 1, 2000. A notice of the anticipated implementation date will be published in the **Federal Register** at least 90 days in advance. The rates that will go into effect on the implementation date will apply to all hospitals including cancer hospitals described in section 1886(d)(1)(B)(v) of the Act. The rates will be based on the rates that would have been in effect January 1, 1999 updated by the rate of increase in the hospital market basket minus one percentage point.

Section 1833(t)(1)(B) of the Act authorizes the Secretary to designate the hospital outpatient services that would be paid under the PPS. Section 1833(t)(1)(B) also requires that the outpatient PPS include inpatient services covered under Part B for beneficiaries who are entitled to Part A benefits but who have exhausted their Part A benefits or otherwise are not in a covered Part A stay. However, section 1833(t)(1)(B) specifically excludes as covered services under the outpatient PPS ambulance services and physical and occupational therapy, and speech-language pathology services, for which separate fee schedules are required by

statute. (See section 4531 of the BBA for amendments pertaining to ambulance services and section 4541 for amendments pertaining to outpatient rehabilitation services.)

Section 1833(t)(2) of the Act stipulates certain requirements for the hospital outpatient PPS. The Secretary is required to develop a classification system for covered outpatient services which may consist of groups arranged so that the services within each group are comparable clinically and with respect to the use of resources. In addition, this section specifies data requirements for establishing relative payment weights, which are to be based on median hospital costs determined by data from the most recent available cost reports; requires that the portion of the Medicare payment and the beneficiary copayment that are attributable to labor and labor-related costs be adjusted for geographic wage differences; and authorizes the establishment of other adjustments, such as outlier adjustments or adjustments for certain classes of hospitals, that are necessary to ensure equitable payments. All adjustments are required to be made in a budget neutral manner. This section concludes with the requirement that a control on unnecessary increases in the volume of covered services be established.

Section 1833(t)(3) provides for a new method of calculating beneficiary copayment. It freezes beneficiary copayment at 20 percent of the national median charges for covered services (or group of covered services) furnished during 1996 and updated to 1999 using the Secretary's estimated charge growth from 1996 to 1999. This section specifies how beneficiary deductibles are to be treated in calculating the Medicare payment and beneficiary copayment amounts and requires that rules be established regarding determination of copayment amounts for covered services that were not furnished in 1996. Further, it prescribes the formula for calculating the initial conversion factor used to determine Medicare payment amounts for 1999 and the method for updating the conversion factor in subsequent years.

Sections 1833(t)(4) and (t)(5) describe the basis for determining the Medicare payment amount and the beneficiary copayment amount for services covered under the outpatient PPS. The latter section requires the Secretary to establish a procedure whereby hospitals may voluntarily elect to reduce beneficiary copayment for some or all covered services to an amount not less than 20 percent of the Medicare payment amount. Hospitals are further allowed to advertise any such reductions of copayment amounts. Section 4451 of the BBA added section 1861(v)(1)(T) to the Act, which stipulates that bad debts will not be recognized on any copayment the hospital elects to reduce.

Section 1833(t)(6) authorizes periodic review and revision of the payment groups, relative payment weights, wage index, and conversion factor.

Section 1833(t)(7) describes how payment is to be made for ambulance services, which are specifically excluded from the outpatient PPS under section 1833(t)(1)(B).

Section 1833(t)(8) provides that the Secretary may establish a separate conversion factor for determining services furnished by cancer hospitals excluded from inpatient PPS under this PPS.

Section 1833(t)(9) prohibits administrative or judicial review of the PPS classification system, the groups, relative payment weights, adjustment factors, other adjustments, calculation of base amounts, periodic adjustments, and the establishment of a separate conversion factor for those cancer hospitals excluded from inpatient PPS.

Section 4523(d) of the BBA amends section 1833(a)(2)(B) of the Act to require payment under the PPS for some services described in section 1832(a)(2) that are currently paid on a cost basis and furnished by providers of services such as comprehensive outpatient rehabilitation facilities (CORFs), home health agencies (HHAs), hospices, and community mental health centers (CMHCs). This amendment requires that partial hospitalization services furnished by CMHCs beginning January 1, 1999 be paid under the PPS. As noted earlier, implementation of the PPS will be delayed. Implementation will occur as soon as possible after January 1, 2000.

II. Elimination of Formula-Driven Overpayment

Before enactment of section 4521 of the BBA, under the blended payment formulas for ASC procedures, radiology, and other diagnostic services, the ASC or physician fee schedule portion of the blends was calculated as if the beneficiary paid 20 percent of the ASC rate or physician fee schedule amount instead of the actual amount paid, which was 20 percent of the hospital's billed charges. Section 4521 corrects this anomaly by changing the blended calculations so that all amounts paid by the beneficiary are subtracted from the total payment in determining the amount due from the program. Effective for services furnished on or after October 1, 1997, payment for surgery, radiology, and other diagnostic services under blended payment methods will be calculated by subtracting the full amount of copayment due from the beneficiary (based on 20 percent of the hospital's billed charges).

III. Extension of Cost Reductions

Section 1861(v)(1)(S)(ii) of the Act requires that the amounts otherwise payable for hospital outpatient operating costs and capital costs be reduced by 5.8 percent and 10 percent, respectively. These reductions were scheduled to sunset at the end of fiscal year 1998, but section 4522 of the BBA extended the reductions through December 31, 1999.

IV. Prohibition Against Unbundling of Hospital Outpatient Services

A. Background

The Social Security Amendments of 1965 (Public Law 89–97), enacted on July 30, 1965, established title XVIII of the Act, which authorized the establishment of the Medicare program to pay part of the costs of health care services furnished to eligible beneficiaries. Part A of the program (Hospital Insurance) provides basic health insurance protection against the costs of inpatient or home health care. Part B of the program (Supplementary Medical Insurance) provides voluntary supplementary insurance covering most physician services and certain other items and services not covered under Part A, including hospital outpatient services.

Before the enactment of Public Law 98–21 on April 7, 1983, which established the Medicare PPS for inpatient hospital services, nonphysician services furnished to Medicare beneficiaries who were hospital patients were generally billed by the hospitals. Under certain circumstances, however, Part B of the Medicare statute permitted payments to be made to an outside supplier or another provider for certain nonphysician services otherwise covered by Medicare Part B that were furnished to a hospital patient. When payments were made under these circumstances, some nonphysician services were billed as hospital services in one hospital and billed by an outside supplier in another. The practice of billing by suppliers outside the hospital for these services has been referred to in the legislative history as the ''unbundling'' of hospital services.

Since the enactment of Public Law 98–21 and the publication of implementing regulations on September 1, 1983 (48 FR 39752), the Medicare program has required that nonphysician

services furnished to hospital inpatients be covered and paid for under Medicare as hospital services. This practice of covering nonphysician services furnished to hospital inpatients by an outside supplier as hospital services is referred to as ''bundling.'' Under the PPS for inpatient hospital services, a single predetermined payment is made for a case based on the diagnosis-related group (DRG) to which the case is assigned. Bundling ensures that the DRG payments to all hospitals cover a comparable ''bundle'' of services related to the hospital stay.

Specifically, Public Law 98–21 added section 1862(a)(14) to the Act to prohibit payment for services (other than physician services) furnished to an inpatient of a hospital by an entity other than the hospital, unless the services are furnished under an arrangement (as defined in section 1861(w)(1) of the Act). (Section 1861(w)(1) of the Act specifies that the term ''arrangements'' is limited to arrangements under which receipt of payment by the hospital or other provider for Medicare-covered services to an individual discharges the liability of the individual or any other person to pay for the services.) Public Law 98–21 also added section 1866(a)(1)(H) to the Act to provide that a hospital is eligible to participate in the Medicare program only if the hospital agrees to furnish to inpatients either directly or under an arrangement all Medicare-covered items and services, other than physician services.

Regardless of whether the hospital furnishes the services directly or arranges for furnishing the services, the hospital assumes financial responsibility for the services. The Medicare program makes payment only to hospitals and not to other providers or suppliers that furnish inpatient services on behalf of the hospitals.

In Public Law 98–21, the Congress addressed only nonphysician services furnished to Medicare beneficiaries who are hospital inpatients. The Congress did not address at that time nonphysician services furnished to Medicare beneficiaries who are hospital outpatients, for which payment is made, usually on a cost basis, under Part B of Medicare. Thus, services to hospital outpatients continued to be unbundled in some hospitals. Subsequently, in section 9343(c) of OBRA 1986, the Congress extended the bundling provision to all nonphysician services furnished to hospital ''patients,'' thus also including nonphysician services furnished to Medicare beneficiaries who are hospital outpatients.

Sections 9343(c)(1) and (c)(2) of OBRA 1986 amended sections 1862(a)(14) and 1866(a)(1)(H) of the Act, respectively. As revised, section 1862(a)(14) of the Act prohibits payment for nonphysician services furnished to hospital patients (inpatients and outpatients), unless the services are furnished by the hospital, either directly or under an arrangement (as defined in section 1861(w)(1) of the Act). As revised, section 1866(a)(1)(H) of the Act requires each Medicare-participating hospital to agree to furnish directly all covered nonphysician services required by its patients (inpatients and outpatients) or to have the services furnished under an arrangement (as defined in section 1861(w)(1) of the Act). Section 9338(a)(3) of OBRA 1986 affected implementation of the bundling mandate by amending section 1861(s)(2)(K) of the Act to permit services of physician assistants to be covered and billed separately.

Bundling of outpatient hospital services was required in order to provide a basis for implementing another provision of OBRA 1986, which required the development of a prospective payment methodology for outpatient hospital services. Section 9343(f) of OBRA 1986 amended section 1135 of the Act to require the Secretary to submit to the Congress by April 1, 1988, an interim report concerning development of a fully prospective payment system for ambulatory surgery. The legislation also specified that a final report was due to the Congress no later than April 1, 1989, with recommendations concerning implementation of a fully prospective payment mechanism for ambulatory surgery services by October 1, 1989. We released an interim report in June of 1988 and the final report in September of 1990. The final report summarized our research findings relating to hospital outpatient prospective payment and did not contain specific recommendations regarding a PPS for ambulatory surgical services. Later, in section 4151(b)(2) of OBRA 1990, the Congress expanded its earlier request and required HCFA to develop a PPS that included all hospital outpatient services. That legislation also directed us to submit a report to the Congress concerning this proposal. We submitted a report to the Congress on March 17, 1995.

In order for us to be able to develop a PPS for hospital outpatient services, it was necessary to have available clear and consistent rules about the range of services that would be included in this payment system. Previous policies on coverage of hospital outpatient services permitted services to be unbundled and thus allowed providers to vary their practices concerning the furnishing of services. The Congress recognized the inconsistencies of the current payment system and required bundling as a first step toward payment reform.

B. Previous Medicare Regulations Affecting Bundling

Previous regulations set forth at 42 CFR 405.310(m) concerning noncoverage of certain services furnished to hospital inpatients (redesignated as § 411.15(m)) implemented the statutory requirement for bundling of inpatient hospital services. They excluded from coverage nonphysician services furnished to hospital inpatients by an entity other than the hospital, unless the services were furnished under an arrangement. The exclusion from coverage in effect at that time did not apply to physician services that met the conditions for payment for physician services to provider patients in § 405.550(b) (redesignated as § 415.102(a)), or services of anesthetists employed by physicians that met the conditions for payment in § 405.553(b)(4) concerning reasonable charges for anesthesiology services furnished by the anesthesiologist or by an anesthetist employed by the anesthesiologist. (The regulation is now deleted as the payment structure for anesthesiologists has changed.) The exception for physician services is required by section 1862(a)(14) of the Act. Services of physician-employed anesthetists were exempted from bundling as an administrative measure to prevent disruption of long-standing physician-anesthetist team relationships. However, in a final rule published on May 26, 1993 (58 FR 30630), the regulations set forth at § 411.15(m) and § 489.20(d) were revised to reflect the statutory exclusion of certified registered nurse anesthetist (CRNA) services (including services of anesthesiologist assistants), physician assistant services, certified nurse midwife services, and qualified psychologist services from the inpatient bundling requirement. Section 411.15(m) concerns services to hospital inpatients excluded from coverage, and § 489.20(d) concerns a provider agreement in the case of a hospital or critical access hospital (CAH) to furnish directly or make arrangements for Medicare-covered services to inpatients of a hospital or a CAH.

C. Office of Inspector General (OIG) Civil Money Penalty Authority

In order to prevent the unbundling of nonphysician hospital services, section 9343(c)(3) of OBRA 1986 amended section 1866 of the Act by adding a new paragraph (g). Specifically, this

authority provided for the imposition of a civil money penalty (CMP), not to exceed $2,000, against any person who knowingly and willfully presents, or causes to be presented, a bill or request for payment for a hospital outpatient service under Part B of Medicare that violates the requirement for billing under arrangements specified in section 1866(a)(1)(H) of the Act. Section 1866(g) was further amended by section 4085(i)(17) of OBRA 1987. Section 4085(i)(17) of OBRA 1987 deleted all references to hospital outpatient services under Part B of Medicare and authorized imposition of a CMP when arrangements should have been made but were not. Section 1866(g) of the Act authorizes imposition of a CMP against any person who knowingly and willfully presents, or causes to be presented, a bill or request for payment inconsistent with an arrangement under section 1866(a)(1)(H) or in violation of the requirement for an arrangement. The result of this amendment is that the CMP is now applicable for all services furnished to hospital patients, whether paid for under Medicare Part A or B. The statute also requires that a CMP be imposed in the same manner as other CMPs are imposed under section 1128A of the Act. Section 231(c) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191) revised section 1128A of the Act to increase the CMP maximum amount for each false claim or prohibited practice from $2,000 to $10,000. Implementing regulations for this authority are set forth in 42 CFR parts 1003 and 1005.

To implement the provisions of section 9343(c) of OBRA 1986, we published a proposed rule in the **Federal Register** on August 5, 1988 (53 FR 29486). Those regulations have not been published in final, but we are proposing revised implementing regulations as part of this regulation.

D. Proposed Regulations Published August 5, 1988

1. Bundling of Hospital Outpatient Services

We proposed to implement the requirement for bundling of outpatient hospital services by amending then existing Medicare regulations (§ 405.310 concerning particular services excluded from coverage, and part 410 concerning supplementary medical insurance benefits) to exclude coverage of any services that are furnished in a hospital to an outpatient of the hospital by an entity other than the hospital during or as a result of an encounter in the hospital, unless the services are furnished under an arrangement. In addition, we proposed to require bundling of those diagnostic procedures or tests (for example, magnetic resonance imaging procedures) that are furnished outside the hospital by an entity other than the hospital but are ordered during an encounter in the hospital with the patient or as a result of such an encounter.

In the proposed rule, in § 405.310(n)(1) concerning definitions of services to hospital outpatients excluded from coverage (now redesignated as § 411.15(m)), we defined a hospital outpatient as an individual who is not an inpatient of the hospital but who is registered as an outpatient.

We proposed to define, in § 410.2 (''Definitions''), the term ''encounter'' as a direct personal contact between a patient and a physician, or other person who is authorized by State licensure law and, where applicable, by hospital staff bylaws, to order or furnish services for the patient for the purpose of diagnosis or treatment of the patient. The use of the ''encounter'' as a basis for identifying the services to be bundled is not specifically required by OBRA 1986 but is needed in order to implement the bundling requirement in a uniform and equitable manner, as explained further in section III. of the preamble of the August 5, 1988 proposed rule (53 FR 29489).

As in the case of services to hospital inpatients, physician services that meet the conditions for payment for services of physicians to provider patients in § 415.102(a) would not be bundled under our proposal. (The exception for physician services is required by section 1862(a)(14) of the Act.) We also proposed, as an administrative measure, to exempt from outpatient bundling the services of physician-employed anesthetists that meet the conditions for payment for services furnished by an anesthesiologist or by an anesthetist employed by the anesthesiologist in § 405.553(b)(4). These services were exempted from bundling to prevent disruption of long-standing physician-anesthetist team relationships. We also proposed to exempt physician assistant services as defined in section 1861(s)(2)(K)(i) of the Act from inpatient and outpatient bundling. We proposed this change to help accomplish the objective of section 1861(s)(2)(K)(i) of the Act, as amended by section 9338(a)(3) of OBRA 1986, which permits physician assistant services to be covered and to be billed separately. As noted earlier, we have made the changes in the types of services excluded from bundling of inpatient services in the May 1993 final rule (58 FR 30630).

We also proposed to revise the regulations set forth at § 489.20, which describe the basic commitments included in the provider agreement. They would require a hospital that furnishes services to a beneficiary who is not currently an inpatient of a hospital but who is registered by the hospital as an outpatient to agree either to furnish directly or to make arrangements (in accordance with section 1861(w)(1) of the Act) for all items and services for which bundling is required under the proposed revision described above, and for which the beneficiary is entitled to have payment made under Medicare.

We proposed in the August 5, 1988 proposed rule that if a Medicare outpatient is referred to another provider or supplier for further diagnostic testing or other diagnostic services as a result of an encounter that occurs in the hospital, the hospital would be responsible for arranging with the other entity for the furnishing of services. (We have now changed our view on bundling of these services as discussed in the following section IV.E.) Also, the hospital would be responsible for furnishing or arranging for the furnishing of prostheses and prosthetic devices (other than dental) that replace all or part of an internal body organ (for example, intraocular lenses (IOLs)) and are implanted or fitted during an encounter. For example, in the absence of a bundling provision, the physician who implants an IOL during surgery performed on an outpatient of a hospital also could be the supplier of the IOL and could bill Medicare under Part B for it. As proposed in our August 1988 rule, this practice would be prohibited, and the hospital would have to furnish the IOL, either directly or under an arrangement (that is, would have to pay for the lens). The same policies would apply to other items and services, such as artificial limbs, knees, and hips; orthotics; equipment and supplies covered under the prosthetic device benefit; and services incident to physician services. Thus, hospitals would be required to assume financial liability for prostheses and prosthetic devices (which are regarded as ''services'' for Medicare coverage purposes) and for other services furnished by an outside entity to their outpatients, and the practice of unbundling these services would be prohibited.

Sometimes a hospital may furnish an item or service for which a patient will have a continuing need. For example, a hospital may furnish a DME item such as a wheelchair. When this situation occurs, the proposed rule required that

the hospital would be responsible for bundling the items and services it furnishes on-site. In adopting the view that these types of items are subject to bundling, we did not discount the patient's continuing need for them after leaving the hospital. However, the bundling provisions in sections 1862(a)(14) and 1866(a)(1)(H) of the Act prohibit unbundling of services to an individual who is a patient of a hospital and do not provide any specific exception to these provisions for DME. Therefore, we did not believe it would be appropriate to exclude DME from bundling when it was furnished to a hospital patient. (We have now changed our previous position on bundling of DME as discussed in section IV.E.)

2. Civil Money Penalties for Unbundling Hospital Outpatient Services

In order to implement section 1866(g) of the Act, in our August 5, 1988 proposed rule, we proposed that the OIG would impose a CMP against any person who knowingly and willfully presents, or causes to be presented, a bill or request for payment for a hospital outpatient service under Part B of Medicare that violates the billing arrangement under section 1866(a)(1)(H) of the Act or the requirement for an arrangement. The amount of the CMP was to be limited to $2,000 for each improper bill or request, even if the bill or request included more than one item or service. However, in accordance with the Health Insurance Portability and Accountability Act of 1996, which increased the minimum penalty amount to $10,000, the increased amount will now be reflected in the regulations.

E. Revised Proposed Regulations on Bundling of Hospital Services

This proposed rule incorporates most of the provisions of the August 5, 1988 proposed rule. The following describes how the regulations published in this proposed rule to implement the rebundling of outpatient hospital services differ from the regulations we proposed and published on August 5, 1988:

- We are not including any of the changes in the regulations relating to payment for physician laboratory services (§§ 405.555(a) through (c), and 405.556(c) of the August 5, 1988 proposed rule), because these regulations were deleted as a result of publication of regulations to implement the Medicare physician fee schedule published on November 25, 1991 (56 FR 59502).
- We are revising § 409.10(b), which describes services that are not included in the definition of ''hospital inpatient or inpatient CAH services'' to include all of the services that are now exceptions from the bundling rule under section 1862(a)(14) of the Act. Section 4511 of the BBA revised sections 1862(a)(14) and 1866(a)(1)(H) of the Act to exclude services of nurse practitioners and clinical nurse specialists described in section 1861(s)(2)(K) of the Act from the bundling requirement.
- As previously indicated, proposed § 410.2 had been revised in the earlier proposed rule to include a definition of an ''encounter.'' The definition of an encounter is expanded to include encounters in a CAH. That section is further amended to include a definition of an ''outpatient'' as a person who has not been admitted as an inpatient but who is registered on the hospital or CAH records as an outpatient and receives services (rather than supplies alone) directly from the hospital or CAH. The revision to include CAHs in these definitions is made to comply with sections 1862(a)(14) and 1866(a)(1)(H) of the Act, which require that CAHs be treated as hospitals for purposes of the bundling provisions. (The BBA eliminated rural primary care hospitals (RPCHs) and created CAHs. The Congress intended, under section 4201(c) of the BBA, that CAHs be subject to the same Medicare requirements to which RPCHs were subject.)
- The revision to § 410.27 is the same as in the earlier proposed rule except that the revision is now designated as paragraph (e) instead of paragraph (c).
- We are removing paragraph (a)(4) of § 410.28 (''Hospital or CAH diagnostic services furnished to outpatients: Conditions'') to reflect a change made by section 4085(i)(11) of OBRA 1987 regarding provisions of diagnostic services furnished to outpatients.
- Proposed § 410.30 (redesignated as § 416.39 in this proposed rule) is being significantly revised. In § 410.30(a) and (b) (now § 410.39 (a) and (b) of regulations published on August 5, 1988, we proposed to require the hospital to furnish directly or under arrangements all services furnished to its outpatients during an encounter as well as any diagnostic services furnished outside the hospital that were ordered during or as a result of an encounter in the hospital. In this rule, we are not extending the bundling requirements to include diagnostic services ordered during an encounter in the hospital that are furnished outside the hospital. Thus, the hospital will not be required to furnish such diagnostic services directly or under arrangements. We are proposing a more limited approach to bundling because the PPS we are proposing involves less ''packaging'' than we anticipated when we published the August 1988 proposed regulations. At that time, we believed that a PPS payment for a surgical procedure was likely to include preoperative tests and that payment for a clinic visit was likely to include the ancillary services (for example, laboratory tests and x-rays) that were needed to make a diagnosis. Therefore, by requiring bundling of off-site diagnostic tests that were ordered during an outpatient encounter at the hospital, we believed we could ensure that: (1) We had sufficient data to set payment rates that included the ancillary tests, and (2) once the system was implemented, the bundling rules would prevent any duplication of program payments. That is, a service packaged into a PPS payment to the hospital could not also be billed to the program as an ancillary test by an outside entity.

  As noted above, the PPS we are proposing now does not include extensive packaging; therefore, the payment for related diagnostic tests is not included in the payments under the ambulatory payment classification (APC) groups for surgical procedures, clinic visits, emergency room visits, etc. Any diagnostic tests that are furnished will result in a separate payment. The program will pay the entity that actually furnishes the service—the hospital, if the service is provided directly or under arrangements made by the hospital; or another Medicare recognized entity, if the patient leaves the hospital and obtains the service elsewhere. Because diagnostic tests are not being packaged into another hospital service, we no longer need to require that a hospital furnish directly or under arrangements the services ordered during, or as a result of, an encounter, but furnished outside the hospital. If the PPS is changed in future years to require a more packaged approach to payment, the bundling regulations will be revised. Proposed § 410.30 (now § 410.39) is also revised to require that the bundling rules apply to CAHs, and the list of services that are excepted from the bundling requirements, in § 410.30(b) (now § 410.39(b)) (previously designated in the August 5, 1988, proposed rule as § 410.30(c)), is expanded to include all of the services that are currently excepted under section 1862(a)(14) of the Act.
- We are revising § 411.15(m) (previously designated as § 405.310(m)) significantly. We are eliminating proposed § 405.310(n). That section, which had described the hospital

outpatient services that were excluded from coverage if not furnished directly or under arrangements, has been revised so that we will not require that hospitals bundle diagnostic services ordered during or as a result of an encounter in the hospital if furnished outside the hospital. The requirements of that section have been incorporated into § 411.15(m)(1). We are revising § 411.15(m)(2), which describes the services that are exceptions to the bundling rule, to include all of the services that are now exceptions under section 1862(a)(14) of the Act. We are further revising § 411.15(m)(3), ''Scope of exclusion,'' to delete the reference to DME as a service that must be bundled. DME is defined under section 1861(n) of the Act as equipment used in the patient's home or in another institution used as his home other than a hospital or skilled nursing facility (SNF). By definition, DME is not something that is provided for use in the hospital setting. Therefore, we do not believe that the DME benefit provides for any item or service that is expected to be used by the patient while in the hospital as an inpatient or outpatient. Section 1862(a)(14) of the Act requires the hospital to provide directly or under arrangements services furnished to the patients of a hospital or CAH. We did not provide an exception for DME in our earlier proposed rule, because the bundling requirements under sections 1862(a)(14) and 1866(a)(1)(H) of the Act did not provide an exception for DME. However, we now believe that a statutory exception is not required because the bundling requirements apply to the services a hospital furnishes to its patients, and DME is not a hospital service. The covered Part B benefit for DME as described under section 1861(n) of the Act is intended for equipment used in the home, so a hospital that furnishes DME to its patients is not providing a hospital service to its patients, but is acting in the capacity of a supplier of DME, not a provider of hospital services. For these reasons, we will not require bundling of DME for hospital patients.

- Section 412.50 was not amended in the earlier proposed rule, but we are revising it in this rule to specify that hospital inpatient services do not include the services that are exceptions to the bundling requirements under section 1862(a)(14) of the Act.
- We are revising proposed § 489.20(d) to incorporate as exceptions to the bundling requirements all of the services that are now exceptions under section 1866(a)(1)(H) of the Act.
- In addition to minor wording changes in introductory paragraph (b), proposed § 1003.102 remains the same as in the August 5, 1988 proposed rule, with the exception that the revision is now designated as paragraph (b)(14) rather than as paragraph (b)(4), as originally indicated in the August 5, 1988 proposed rule. Paragraphs (b)(11) through (b)(13) of § 1003.102 are being reserved. We are also amending § 1003.103(a) to indicate, in accordance with section 231(c) of the Health Insurance Portability and Accountability Act, that the maximum CMP for each improper bill or request has been increased to $10,000.
- We are also amending § 1003.105 (Exclusion from participation in Medicare and State health care programs) by revising paragraph (a)(1)(i) to reflect that this basis for imposition of a CMP is also a basis for an exclusion from participation in Medicare and the State health care programs.

V. Hospital Outpatient Prospective Payment System (PPS)

In this proposed rule, we delineate the services that are covered under the hospital outpatient prospective payment system (PPS) that we are required to establish under section 1833(t) of the Act. We also propose Medicare payment rates when those services are ordered or furnished for diagnosis or treatment of a Medicare beneficiary who is registered on hospital records as an outpatient, and who receives services directly from the hospital.

In this section, we explain the framework for the hospital outpatient PPS. This framework rests on Medicare's definition of an outpatient, which we discuss in section IV.E, above, and on Medicare's definition of what constitutes a hospital outpatient department or clinic. In section VI., below, we address requirements to define and distinguish among the various sites where services that are covered under the hospital outpatient PPS could be furnished. For example, a service furnished at an outpatient department or clinic located within a hospital can also be furnished at a ''provider-based'' entity, at a site away from a hospital that functions as though it were a department within the hospital, at an ASC, and at a physician office. Under the statute as it is currently written, in order to determine whether Medicare makes payment for a service under the hospital outpatient PPS that is the subject of this proposed rule or under another provision of Medicare Part B, such as the ASC benefit or the physician fee schedule, it is essential to clarify exactly where and under what conditions the service was furnished.

This PPS will apply to covered hospital outpatient services furnished by any hospital participating in the Medicare program, except for those hospitals discussed below. Partial hospitalization services in community mental health centers (CMHCs) will also be paid under this PPS.

The cancer hospitals that are excluded from inpatient PPS will be paid under hospital outpatient PPS. Although the BBA provides for a separate conversion factor if necessary, we intend to pay cancer hospitals using the same conversion factor and rates as all other hospitals. Certain hospitals in Maryland furnish services that are exempt from this system because they qualify under section 1814(b)(3) of the Act for payment under the State's payment system. Such excluded services are limited to the services paid under the State's payment system as described in section 1814(b)(3) of the Act. Any other outpatient services furnished by the hospital will be paid under the outpatient PPS. Critical access hospitals are excluded from the outpatient PPS because they are paid under a reasonable cost based system, as required under section 1834(g) of the Act. All other participating hospitals will be paid under hospital outpatient PPS.

Distinct parts of hospitals that are excluded under inpatient PPS will be included in the outpatient PPS, to the extent that outpatient services are furnished by the hospital. For example, a hospital with an excluded inpatient psychiatric unit will have payment made under this PPS for outpatient psychiatric services including to inpatients who are not in a covered Part A stay.

A. Scope of Services Within the Outpatient PPS

Section 1833(t)(1)(B)(i) of the Act gives the Secretary the authority to designate which services are to be covered under the hospital outpatient PPS. In this section, we indicate the types of services for which we are proposing to make payment under the hospital outpatient PPS and the types of services we are proposing to exclude from the scope of the hospital outpatient PPS.

Section 1833(t)(2)(A) of the Act requires the Secretary to develop a classification system for the services that she designates are covered under the hospital outpatient PPS. Section 1833(t)(2)(B) of the Act allows the Secretary to classify covered outpatient services by groups so that the services within each are comparable clinically and with respect to the use of resources.

We refer to the hospital outpatient PPS classification system that we have developed as the Ambulatory Payment Classification (APC) system. The APC system consists of 346 groups of services that are covered under the hospital outpatient PPS.

In section V.B., below, we explain how we assigned services and procedures to APC groups and in sections V.C. and V.D., below, we explain how we used the APC groups to determine hospital outpatient PPS payment rates.

1. Services Excluded From the Hospital Outpatient PPS

Section 1833(t)(1)(B)(iii) of the Act excludes the following from payment under the hospital outpatient PPS: ambulance services, physical and occupational therapy, and speech-language pathology services. These services will be paid under fee schedules in all settings.

Section 1833(t)(1)(B)(i) of the Act gives the Secretary the authority to designate which hospital outpatient services are covered under the outpatient PPS. In considering which services to include under the outpatient PPS, we wanted to ensure that all hospital outpatient services are paid under a prospectively determined amount. Some hospital outpatient services (for example, clinical diagnostic laboratory services, orthotics and prosthetics, ESRD dialysis services) are currently paid based on fee schedules or other prospective rates. Payments under these fee schedules apply not only to hospital outpatient services, but the same or very similar payment rates apply across a number of sites of ambulatory care. Such similar payments across various settings creates a level playing field where HCFA pays virtually the same payment for the same service, without regard to where the service is furnished. So that we do not disrupt an existing level playing field, we propose to exclude from our PPS, hospital outpatient services that are currently paid prospectively determined rates that are the same rates paid in other settings.

We are proposing to exclude from the hospital outpatient PPS the following:

a. Certain services already paid for under fee schedules or other payment systems including, but not limited to, services for patients with ESRD that are paid for under the ESRD composite rate; laboratory services paid under the clinical diagnostic laboratory fee schedule; and DME, orthotics, prosthetics, prosthetic devices, prosthetic implants and supplies (DMEPOS) paid for under the DMEPOS fee schedule when the hospital is acting as a supplier of these items. An item such as crutches or a walker that is given to the patient to take home, but that may also be used while the patient is at the hospital, would be billed to the DME regional carrier rather than being paid for under the hospital outpatient PPS.

b. Hospital outpatient services furnished to inpatients of an SNF regardless of whether the person is in a Part A covered stay and furnished pursuant to the resident assessment or comprehensive care plan and that are covered under the SNF PPS, furnished ''under arrangements'' and billable only by the SNF.

c. Services and procedures that require inpatient care.

MedPAC Recommendation: In its March 1998 report to the Congress, the Medicare Payment Advisory Commission (MedPAC) recommends that costs associated with allied health professions training, such as nursing schools and paramedical education, be excluded from the calculation of the relative weights and the conversion factor used to set outpatient PPS payment rates. MedPAC further recommends that Medicare make separate payment for these costs, consistent with the manner in which Medicare pays for allied health professions training costs under the inpatient PPS.

Response: We agree with MedPAC's recommendation. We did not include costs associated with allied health professions training in the calculation of outpatient PPS relative weights and conversion factors. We propose to pay hospitals that have allied health professions training programs on a cost-pass-through basis similar to the way we treat these costs under the hospital inpatient PPS.

2. Services Included Within the Scope of the Hospital Outpatient PPS

a. Services for Patients Who Have Exhausted Their Part A Benefits

Section 1833(t)(1)(B)(ii) of the Act provides for Medicare payment under the hospital outpatient PPS for certain services furnished to inpatients who have exhausted Part A benefits or otherwise are not in a covered Part A stay. Examples of services covered under this provision include diagnostic x-rays and certain other diagnostic services and radiation therapy covered under section 1832 of the Act.

b. Partial Hospitalization Services

Section 1833(a)(2)(B) of the Act provides that partial hospitalization services furnished in CMHCs be paid for under the hospital outpatient PPS. Partial hospitalization is a distinct and organized intensive psychiatric outpatient day treatment program, designed to provide patients with profound and disabling mental health conditions an individualized, coordinated, comprehensive, and multidisciplinary treatment program.

c. Services Designated by the Secretary

Under the authority established by the statute at section 1833(t)(1)(B)(i), we further are proposing to include within the scope of services for which payment is made under the hospital outpatient PPS the following:

- Services that are included within the outpatient PPS system are all hospital outpatient services that have not been identified for exclusion as described in section V.A.1., above. Among the types of services that we have classified into APC groups for payment under the hospital outpatient PPS are the following: surgical procedures; radiology, including radiation therapy; clinic visits; emergency department visits; diagnostic services and other diagnostic tests; partial hospitalization for the mentally ill; surgical pathology; cancer chemotherapy.
- Services furnished to SNF inpatients that are not packaged into SNF consolidated billing precisely because they are services that are commonly furnished by hospital outpatient departments and that SNFs would not be able to provide, such as CT scans, magnetic resonance imaging, or ambulatory surgery requiring the use of an operating room.
- Supplies such as surgical dressings that can be used during surgery or other treatments in the hospital outpatient setting that are also on the DMEPOS fee schedule. Payment for such supplies, when they are used in the hospital, is packaged into the APC payment rate for the procedure or service with which the items are associated.
- Certain preventive services furnished to healthy persons, such as colorectal cancer screening.

Section 4523(d)(3) of the BBA provides that we will make Part B payment for certain medical and other health services, when furnished by a provider of services or by others under arrangement with a provider of services, under the outpatient PPS, if we would otherwise pay those providers on a reasonable cost basis for those services. Specifically, we are proposing that we would pay for the following medical and other health services under the

outpatient PPS when furnished by a provider of services:

- Antigens (as defined in 1861(s)(2)(G) of the Act);
- Splints and casts (1861(s)(5));
- Pneumococcal vaccine, influenza vaccine, hepatitis B vaccine (1861(s)(10)).

We make Part B payment for the above services under the outpatient PPS when those services are provided by a CORF, HHA, or hospice program. However, this provision does not apply to services, furnished by a CORF, that fall within the definition of CORF services at section 1861(cc)(1) of the Act. It also does not apply to services furnished by a hospice within the scope of the hospice benefit. Nor does it apply to services furnished by HHAs to individuals under an HHA plan of treatment within the scope of the home health benefit.

3. Hospital Outpatient PPS Payment Indicators

Column B in Addendum B indicates the payment status of each HCPCS code. Addendum B displays all HCPCS codes, including those incidental services that are packaged into APC payment rates. Addendum G identifies inpatient services not payable under outpatient PPS.

- We use ''A'' to indicate services that are paid under some other method such as the DMEPOS fee schedule or the physician fee schedule.
- We use ''E'' to indicate services for which payment is not allowed under the hospital outpatient PPS or is not covered by Medicare.
- We use ''C'' to indicate inpatient services that are not payable under the outpatient PPS.
- We use ''N'' to indicate services that are incidental, with payment packaged into another service or APC group.
- We use ''P'' to indicate services that are paid only in partial hospitalization programs.
- We use ''S'' to indicate significant procedures for which payment is allowed under the hospital outpatient PPS but to which the multiple procedure reduction does not apply.
- We use ''T'' to indicate surgical services for which payment is allowed under the hospital outpatient PPS. Services with a payment indicator ''T'' are the only services to which the multiple procedure payment reduction applies.
- We use ''V'' to indicate medical visits for which payment is allowed under the hospital outpatient PPS. Providers must use ICD–9–CM (International Classification of Diseases, Ninth Edition, Clinical Modification) codes to determine the level of payment for services with a payment indicator ''V''.
- We use ''X'' to indicate ancillary services for which payment is allowed under the hospital outpatient PPS.

The table below lists all of the outpatient PPS indicators and what they designate.

STATUS INDICATORS

[How Medicare Pays for Various Services When They Are Billed for Hospital Outpatients]

Indicator	Service	Status
A	Pulmonary Rehabilitation; Clinical Trial	Non-paid.
C	Inpatient Procedures	Bill as Inpatient.
A	Durable Medical Equipment, Prosthetics and Orthotics	DMEPOS Fee Schedule.
E	Non-covered Items and Services	Non-paid.
A	Physical, Occupational and Speech Therapy	Rehab Fee Schedule.
A	Ambulance	Ambulance Fee Schedule.
A	EPO for ESRD patients	National Rate.
A	Clinical Diagnostic Laboratory Services	Lab Fee Schedule.
A	Physician Services for ESRD patients	Bill to carrier.
A	Screening Mammography	Lower of Charge or National Rate.
N	Incidental Services, packaged into APC Rate	Packaged; no additional payment allowed.
P	Partial Hospitalization Services	Paid per diem.
S	Significant Procedure, not reduced when multiple	Paid under hospital outpatient PPS (APC rate).
T	Significant Procedure, multiple procedure reduction applies	Paid under hospital outpatient PPS (APC rate).
V	Visit to Clinic or Emergency Department	Paid under hospital outpatient PPS (APC rate).
X	Ancillary Service	Paid under hospital outpatient PPS (APC rate).

B. Description of the Ambulatory Payment Classification (APC) Groups

In response to OBRA 1986 and OBRA 1990 requirements to develop a hospital outpatient PPS, we examined systems that were in place or under development, and we entered into a cooperative agreement with 3M-Health Information Systems to develop a classification system for outpatient services. The results of our review of existing systems are outlined in a Report to Congress dated March 17, 1995. The report identified the Ambulatory Patient Groups (APGs), which were developed by 3M-Health Information Systems, as the most promising classification system, and we recommended that APG-like groups be used as the basis for the hospital outpatient PPS. Soon after the report was submitted to the Congress, 3M-Health Information Systems released an updated version (known as Version 2.0) of the APGs. Since the release of Version 2.0, HCFA has revised the APGs based on more recent Medicare data. These revisions constitute what we are calling the Ambulatory Payment Classification (APC) system or groups that are proposed in this rule. Services within the APC system are identified by HCPCS codes and descriptions.

1. Setting Payment Rates Based on Groups of Services Rather Than on Individual Services

MedPAC Recommendation: In its March 1998 report to the Congress entitled ''Report to the Congress: Medicare Payment Policy,'' MedPAC recommends that payment rates under the hospital outpatient PPS be based upon relative weights for each individual service rather than upon groups of similar services to help ensure consistent payments across ambulatory settings. MedPAC gives several reasons to support this recommendation:

- If services in a group are not homogeneous, a single payment rate for

all services in the group would not be accurate.

- Hospitals whose case mix includes a greater than average volume of higher-cost procedures in a group with a payment rate based on median costs for all procedures in the group could face losses and would have a financial incentive to provide only the lower-cost procedures within a group and to avoid the higher-cost procedures.
- Grouping services creates considerable administrative burdens and problems related to data consistency, provider education, the need for extensive technical assistance, and modification of claims processing systems.
- If costs for services in a group change at different rates, the price for the group may become distorted over time, necessitating periodic rebasing of group weights.
- Using groups to set rates for services under the hospital outpatient PPS moves away from standardizing payment systems across ambulatory settings.

Response: We have carefully reviewed MedPAC's concerns about using groups of services rather than individual services as the basis for setting weights under the hospital outpatient PPS, and we believe that we have addressed most of these concerns in our approach to ratesetting using APC groups.

Section 1833(t)(2)(A) of the Act requires the Secretary to develop a classification system for covered outpatient services. Section 1833(t)(2)(B) provides that this classification system may be composed of groups, so that services within each group are comparable clinically and with respect to the use of resources. The statute refers to ''each such service (or group of services),'' implying that we may choose or not choose to group services. We have chosen to set rates for groups of similar services rather than setting rates for individual services for several reasons:

- The composition of the APC groups is based on two premises: the procedures within each group must be similar clinically, and the procedures must be similar in terms of resource costs. As we explain below, we used 3M's APGs as a starting point, but we have subsequently made changes to most of the 3M groups, taking into account 1996 outpatient claims data; data collected in a 1994 survey of ASC costs and charges; data collected in 1995 and 1996 to establish resource-based practice expense relative values under the Medicare physician fee schedule; comments on surgical groupings following an ASC town meeting held at HCFA in July 1996 at which participants reviewed 3M's Version 2.0 surgical APGs for consistency in terms of clinical characteristics and resource costs; and the medical judgment of HCFA's medical advisors. Further, we invite comments on the composition of all the APC groups that are presented in this proposed rule and whether readers believe that further refinements are needed. We request that commenters support their recommendations for changes in the APC groups with data regarding resource costs (time, supplies, equipment, labor requirements) as well as clinical arguments.

We have also solicited comments on the same surgical APC groups that are proposed in this rule as part of a proposed rule entitled ''Update of Ratesetting Methodology, Payment Rates, Payment Policies, and the List of Covered Surgical Procedures for Ambulatory Surgical Centers Effective October 1, 1998'' (HCFA–1885–P), published in the **Federal Register** June 12, 1998 (63 FR 32290). We intend to coordinate our review of all comments submitted timely during the comment period for the hospital outpatient PPS proposed rule and the ASC proposed rule. Any subsequent changes to the APC groups will be used by both payment systems when we set their respective final rates. We have a high level of confidence in the homogeneity of the APC groups that will emerge from this exhaustive review process.

- We have found that, in this context, setting weights at a single code level suggests a level of precision that is often not warranted due either to low procedure volume or questionable cost data.
- Of the 10,500 codes in the HCPCS, over 5,000 describe services that are covered under the hospital outpatient PPS. However, an examination of outpatient claims data for 1997 reveals that as few as 100 HCPCS codes account for more than a third of all coded services billed during that year. MedPAC states in its report to the Congress that its analysis of physician claims for 1996 revealed that more than 90 percent of hospital outpatient volume was accounted for by 300 high volume services. Because so many codes were billed infrequently or not at all, we found ratesetting to be facilitated by grouping together the data that were available for codes that are similar clinically. We disagree with MedPAC's suggestion that we establish payment groups composed only of low-volume procedures. If we were to establish such groups, we would either have to except these groups from the principle of clinical consistency that applies to other APC groups or greatly increase the number of APC groups within the outpatient PPS. And, this approach does not solve the problem of how to establish weights for procedures, whether they are taken individually or in groups, for which we have inadequate cost data. Placing low Medicare volume procedures in APC groups with which they are similar clinically and in terms of resource consumption does not affect the weight established for the group to any appreciable extent because the weight derives from the higher volume procedures within the group.
- Grouping closely related services, and paying the median cost of the group, discourages the upcoding that occurs when individual services that are similar have disparate median costs.
- Using APC groups to set outpatient weights is consistent with the ratesetting method we are proposing for ASCs. In a proposed rule entitled ''Update of Ratesetting Methodology, Payment Rates, Payment Policies, and the List of Covered Surgical Procedures for Ambulatory Surgical Centers Effective October 1, 1998'' (HCFA–1885–P), published in the **Federal Register** June 12, 1998 (63 FR 32290), we propose payment rates for surgical procedures performed in Medicare-approved ASCs using APC surgical groups proposed in this rule.
- Payment rates for new or redefined services can be more reliably established by assigning codes for these services to an existing group of several codes that share characteristics with the new code rather than trying to match it to an equivalent single procedure for which we may or may not have reliable cost data.
- Our experience basing ASC payment rates on groups of codes has proved to be no more burdensome administratively than has our experience with setting weights on a single code basis under the Medicare physician fee schedule. Under the outpatient PPS, with weights set by APC groups, hospitals will continue to use the same HCPCS coding and the same claims forms that they use currently. Any burdens on HCFA or on hospitals necessitating additional technical assistance or systems changes are more a function of implementing an entirely new payment system than of our setting weights on the basis of groups of services instead of on the basis of single procedures or services.

We invite comments on our setting rates on the basis of groups of services rather than on individual codes.

2. How the Groups Were Constructed

3M created APGs by combining procedure codes and diagnosis codes into groups that were clinically related (such as all codes for repair of fractured legs) and analyzing claims data to determine if the codes that were clinically similar also used resources in similar ways (for example, surgical repair would likely be more resource intensive than closed manipulation and casting). The resources that were examined were based on a 3-month sample of all Medicare claims for outpatient services. The sample of nearly 15 million claims was selected from claims paid in 1992 with the charges on each claim matched to departmental cost-to-charge ratios from the hospital that provided the services. The costs that were calculated using billed charges and department cost-to-charge ratios included direct costs, as well as the overhead for performing the services. The APGs were clustered into significant procedures (both surgical and nonsurgical), medical visits (in both clinics and emergency departments), and ancillary services. Other groups captured incidental services (those that would not be paid separately) and procedures for which no payment is made, such as services specifically excluded from Medicare payment by statute.

Our Report to Congress recommended the use of APG-like groups for a hospital outpatient prospective payment system. When the time came to update payment groups for ASCs, which already were paid under a PPS, we decided to propose the use of APG-like groups. The ASC industry was accustomed to eight payment groups, with rates ranging from about $300 to about $900 in roughly $75 increments, without clinical coherence. While interested in our proposal, the ASCs were concerned about perceived misclassifications, with groups containing codes they believed represented divergent resources. To accommodate these concerns, we regrouped many surgical codes, creating more levels within some ranges of groups and otherwise changing 3M's system. We also found it necessary to change the medical APGs. The medical visit groups, which under the APGs were grouped based on the patient's diagnosis, were clearly distinct when laboratory services and plain film x-rays were packaged in, but were much less distinct when those ancillary services related to the visit were not packaged, as will be the case initially under our system. We therefore investigated other approaches to categorizing medical visits that would result in clearly defined payment groups without extensive packaging. We discuss these approaches in section V.B.4., below.

This process of revising 3M's APGs resulted in the development of the set of 346 mutually-exclusive and exhaustive service categories called ambulatory payment classification groups or APCs. The weights of the groups proposed in this rule are based on new data, as required by the BBA. We matched the database of 98 million hospital outpatient claims paid in 1996 to the most recent available cost reports for each hospital, and constructed the groups using these cost data. We defined each outpatient service under the PPS by a HCPCS code and classified it either into one of the APC groups for which an outpatient PPS payment rate is established or into a non-payment category of services that are excluded from the outpatient PPS. A weight is associated with each APC group. See section V.C. of this rule for details on how we calculated the weights. Procedures and services assigned a non-payment classification include services that can be provided only on an inpatient basis; codes or services that are not covered by Medicare; and procedures and services paid under fee schedules or other payment method.

3. Packaging Under the Groups

Packaged services are those that are recognized as contributing to the cost of the services in an APC, but that we do not pay for separately. Under the APC system, packaged services include the operating room, recovery room, anesthesia, medical/surgical supplies, pharmaceuticals, observation, blood, intraocular lenses, casts and splints, donor tissue, and various incidental services such as venipuncture. We ''packaged'' the services (and their costs) within the APC group of procedures with which they were delivered in the base year. Below is a list of the hospital revenue centers from which we derived costs that were packaged within the APC groups. For example, a given surgical procedure would have a cost for the use of the operating and recovery rooms in every case. However, supply costs might vary, with some patients requiring special drains and dressings and others needing minimal dressings. The average packaged cost for supplies might represent, for example, $200 for the former group 40 percent of the time, and $150 for the rest. Thus, the APC would include $170 for supplies. Similarly, only a few cases would have included observation in the base year, but each case in the group would include a small amount for the times we associated observation with the cases in the group.

We have packaged the cost of pharmaceuticals and biologicals within APC groups. We did this because we believe drugs are usually provided in connection with some other treatment or procedure. We have captured aggregate cost data on all drugs that were billed with HCPCS codes and those billed with revenue center codes, whether or not a HCPCS was entered. Thus, historical patterns of drug use are captured within the APC groups with which the drugs were billed during the base year. The only separate drug groups we have created are for chemotherapeutic agents, because those were separately identified in 3M's APG system. Because we intended to use an APG-like system, we required detailed coding of chemotherapeutic agents in order to be able to capture the costs of the specific drugs. We did not require HCPCS coding of other drugs, so we cannot specifically identify costs of non-chemotherapy drugs. We understand, however, that some rarely-used drugs are both expensive and used in only a few hospitals. In those instances, APC payment rates may not adequately represent costs for hospitals that treat patients who require infusions of very costly drugs or biologicals. Because we do not have bills that were coded to identify these high-cost drugs individually, we cannot evaluate the impact of paying separately for high-cost drugs. We could require HCPCS coding of all drugs or certain categories of drugs in order to gather the data, but we know hospitals could find such a requirement burdensome. We solicit comments on this issue.

Currently, drugs that can be self-administered are not covered under Part B of Medicare (with certain specific exemptions for blood-clotting factors, immunosuppresives, erythropoietin for dialysis patients, and certain oral chemotherapeutic agents and antiemetics). This presents problems in the outpatient hospital setting because even a pain killer given to a groggy patient postoperatively would not be covered. The only way such drugs can be paid for is for the hospital to bill the beneficiary. In many cases, the hospital does not, both because keeping track of such small charges for billing purposes is burdensome and because beneficiaries would not understand why they are being asked to pay for, for example, pain medication that was clearly related to the procedure they had undergone.

We propose to allow hospitals to provide drugs to patients without requiring that the hospital bill the

patient, and without Medicare's paying the hospital. Normally, hospitals are not allowed to waive such billing, since not charging a patient could be seen as an inducement to the patient to use other services at the hospital, for which the hospital would be paid. However, if the benefit is not advertised, we believe that provision of the self-administered drugs at no charge to the beneficiary need not constitute an inducement in violation of the anti-kickback rules. The hospital may not advertise this to the public or in any other way induce patients to use the hospital's service in return for forgoing payment.

Recommendation: MedPAC recommends that the unit of payment under the outpatient PPS be the individual service or procedure that is furnished and that payment for services and supplies integral to the individual service or procedure be bundled within that single unit of payment.

Response: We agree both with MedPAC's recommendation regarding what should constitute the unit of payment under the outpatient PPS, and with MedPAC's recommendation regarding the ''bundling'' of payment, which we call ''packaging,'' for supplies and services that are integral to the individual service or procedure that constitutes the unit of payment. All services and procedures for which payment is to be made under the outpatient PPS are identified by HCPCS codes and descriptions. This approach of identifying individual services by HCPCS as the unit for payment parallels the unit for payment under both the Medicare physician fee schedule and the ASC facility services benefit. In addition, as we explain above, the payment amount for each HCPCS code is a packaged payment that takes into account the costs associated with services and supplies that are integral to the primary HCPCS-coded service or procedure and that are furnished at the same time and in the same place as the primary service or procedure. Because we modeled the outpatient PPS package of services for surgical procedures on the package of services that is the basis for payments for facility services furnished by Medicare approved ASCs, the definition of packaging will become standardized across both settings upon implementation of the outpatient PPS.

MedPAC cites as a disadvantage of using individual services or procedures as the unit for payment the limited options that are available to control the volume of unnecessary ancillary services. We discuss in section V.J. how we intend to address volume control under the outpatient PPS. While a broader definition of packaging that includes related ancillaries such as diagnostic x-rays and other diagnostic tests that are furnished in other settings or at a different time than the primary service or procedures may have potential benefits not realized by the more limited packaging that we are using, we are concerned that applying different definitions of packaging to payments for the same primary service furnished in different settings would defeat the goal of establishing a unified payment structure across sites. One component of achieving this goal is to employ a consistent definition of packaging across all sites of ambulatory services. We solicit comments on the packaging options and the implications for ratesetting and volume control of using the same or different definitions of packaging across different settings.

The following table identifies by revenue code the services and items that are packaged into the various categories of APC groups (surgery, radiology, other diagnostic, medical visits, and all other APC groups).

PACKAGED SERVICES BY REVENUE CENTER

SURGERY

250	PHARMACY.
251	GENERIC.
252	NONGENERIC.
257	NONPRESCRIPTION DRUGS.
258	IV SOLUTIONS.
259	OTHER.
270	M&S SUPPLIES.
271	NONSTERILE SUPPLIES.
272	STERILE SUPPLIES.
360	OPERATING ROOM.
361	MINOR SURGERY.
369	OTHER.
370	ANESTHESIA.
379	OTHER.
380	''BLOOD, GENERAL CLASS''.
381	PACKED RED CELLS.
382	WHOLE BLOOD.
383	PLASMA.
384	PLATELETS.
385	LEUCOCYTES.
386	OTHER COMPONENTS.
387	OTHER DERIVATIVES.
389	OTHER BLOOD.
390	BLOOD STORAGE AND PROCESSING.
391	BLOOD ADMINISTRATION.
399	OTHER BLOOD PROC/STORAGE.
490	''AMBULATORY SURGERY, GENERAL CLASS''.
491	OTHER AMBULATORY SURGICAL CARE.
630	DRUGS REQUIRING ID.
631	SINGLE SOURCE DRUG.
632	MULTIPLE SOURCE DRUG.
636	DRUGS REQUIRING DETAILED CODING.
700	CAST ROOM.
709	OTHER.
710	RECOVERY ROOM.
719	OTHER.
720	LABOR ROOM.
721	LABOR.
722	DELIVERY.
723	CIRCUMCISION.
724	BIRTHING CENTER.
729	OTHER.
750	GASTROINTESTINAL.
759	OTHER.
760	OBSERVATION ROOM.
761	TREATMENT ROOM.
762	OBSERVATION ROOM.
769	OTHER TREATMENT ROOM.
890	OTHER DONOR BANK.
891	BONE.
892	ORGAN.
893	SKIN.
899	OTHER.
920	''OTHER DIAGNOSTIC SERVICES, GENERAL CLASS''.
929	OTHER DIAGNOSTIC SERVICES.
940	''OTHER THERAPEUTIC SERVICES, GENERAL CLASS''.
949	OTHER THERAPEUTIC SERVICES.

MEDICAL VISIT

250	PHARMACY.
251	GENERIC.
252	NONGENERIC.
257	NONPRESCRIPTION DRUGS.
258	IV SOLUTIONS.
259	OTHER.
270	M&S SUPPLIES.
271	NONSTERILE SUPPLIES.
272	STERILE SUPPLIES.
279	OTHER.
380	''BLOOD, GENERAL CLASS''.
381	PACKED RED CELLS.
382	WHOLE BLOOD.
383	PLASMA.
384	PLATELETS.
385	LEUCOCYTES.
386	OTHER COMPONENTS.
387	OTHER DERIVATIVES.
389	OTHER BLOOD.
390	BLOOD STORAGE AND PROCESSING.
391	BLOOD ADMINISTRATION.
399	OTHER BLOOD PROC/STORAGE.
630	DRUGS REQUIRING ID.
631	SINGLE SOURCE DRUG.
632	MULTIPLE SOURCE DRUG.
636	DRUGS REQUIRING DETAILED CODING.
762	OBSERVATION ROOM.

DIAGNOSTIC

250	PHARMACY.
251	GENERIC.
252	NONGENERIC.
254	INCIDENT TO OTHER DIAGNOSTIC.
257	NONPRESCRIPTION DRUGS.
258	IV SOLUTIONS.
259	OTHER.
270	M&S SUPPLIES.
271	NONSTERILE SUPPLIES.
272	STERILE SUPPLIES.
360	OPERATING ROOM.
361	MINOR SURGERY.
369	OTHER.
370	ANESTHESIA.
372	INCIDENT TO OTHER DIAGNOSTIC.
379	OTHER.
380	''BLOOD, GENERAL CLASS''.
381	PACKED RED CELLS.
382	WHOLE BLOOD.
383	PLASMA.
384	PLATELETS.
385	LEUCOCYTES.
386	OTHER COMPONENTS.
387	OTHER DERIVATIVES.
389	OTHER BLOOD.
390	BLOOD STORAGE AND PROCESSING.
391	BLOOD ADMINISTRATION.
399	OTHER BLOOD PROC/STORAGE.

PACKAGED SERVICES BY REVENUE CENTER—Continued

450	ER.
459	OTHER.
622	INCIDENT TO OTHER DIAGNOSTIC.
630	DRUGS REQUIRING ID.
631	SINGLE SOURCE DRUG.
632	MULTIPLE SOURCE DRUG.
636	DRUGS REQUIRING DETAILED CODING.
710	RECOVERY ROOM.
719	OTHER.
762	OBSERVATION ROOM.

RADIOLOGY

250	PHARMACY.
251	GENERIC.
252	NONGENERIC.
255	INCIDENT TO RADIOLOGY.
257	NON-PRESCRIPTION DRUGS.
258	IV SOLUTIONS.
259	OTHER.
270	M&S SUPPLIES.
271	NONSTERILE SUPPLIES.
272	STERILE SUPPLIES.
360	OPERATING ROOM.
361	MINOR SURGERY.
369	OTHER.
370	ANESTHESIA.
371	ANESTHESIA INCIDENT TO RADIOLOGY.
379	OTHER.
380	"BLOOD, GENERAL CLASS".
381	PACKED RED CELLS.
382	WHOLE BLOOD.
383	PLASMA.
384	PLATELETS.
385	LEUCOCYTES.
386	OTHER COMPONENTS.
387	OTHER DERIVATIVES.
389	OTHER BLOOD.
390	BLOOD STORAGE AND PROCESSING.
391	BLOOD ADMINISTRATION.
399	OTHER BLOOD PROC/STORAGE.
621	SUPPLIES INCIDENT TO RADIOLOGY.
630	DRUGS REQUIRING ID.
631	SINGLE SOURCE DRUG.
632	MULTIPLE SOURCE DRUG.
636	DRUGS REQUIRING DETAILED CODING.
710	RECOVERY ROOM.
719	OTHER.
762	OBSERVATION ROOM.

ALL OTHER APC GROUPS

250	PHARMACY.
251	GENERIC.
252	NONGENERIC.
257	NONPRESCRIPTION DRUGS.
258	IV SOLUTIONS.
259	OTHER.
270	M&S SUPPLIES.
271	NONSTERILE SUPPLIES.
272	STERILE SUPPLIES.
279	OTHER.
380	"BLOOD, GENERAL CLASS".
381	PACKED RED CELLS.
382	WHOLE BLOOD.
383	PLASMA.
384	PLATELETS.
385	LEUCOCYTES.
386	OTHER COMPONENTS.
387	OTHER DERIVATIVES.
389	OTHER BLOOD.
390	BLOOD STORAGE AND PROCESSING.
391	BLOOD ADMINISTRATION.
399	OTHER BLOOD PROC/STORAGE.
630	DRUGS REQUIRING ID.
631	SINGLE SOURCE DRUG.
632	MULTIPLE SOURCE DRUG.

PACKAGED SERVICES BY REVENUE CENTER—Continued

636	DRUGS REQUIRING DETAILED CODING.
762	OBSERVATION ROOM.

4. Treatment of Clinic and Emergency Visits

The major issue we face in determining payment for clinic and emergency room visits is whether to include diagnosis as well as *Physicians' Current Procedural Terminology* (CPT) codes in setting payment rates. We solicit comments on the approaches that we discuss below and on other possible alternatives.

Determining payment for clinic and emergency room visits requires a variety of considerations and trade-offs. These include:

- The impact of packaging on setting payment rates (for example, the more packaging, the greater the difference among APC payments; however, we are not proposing a fully packaged system initially, which reduces payment differences and may necessitate additional policies to increase differences across payment groups);
- How to code visits in a manner that recognizes variations in service intensity and levels of resource consumption (for example, how to pay more for visits that cost more);
- How to keep the system administratively manageable (for payment purposes, we assign 31 CPT codes that describe different levels of evaluation and management services to 7 APC groups);
- How to define critical care in terms of facility as opposed to physician inputs (for example, what is an appropriate facility payment for critical care when critical care CPT codes are currently determined to reflect physician inputs);
- Data problems associated with identifying costs from claims that list multiple services (for example, the data analysis we have conducted so far reflects only data from claims for single visits; we are analyzing data from multiple visit claims to glean additional information relevant to these policies);
- How to move toward greater uniformity of payments across ambulatory settings so as to remove payment as an incentive for determining site of service (for example, the trade-off that could result if, by enhancing differentiation of payments for services within the hospital outpatient setting, we were to increase payment differences across settings for services that are provided in both hospital outpatient departments and physician offices).

Given the range of issues surrounding payments for clinic and emergency room visits, we are continuing to weigh different options. We are concerned that using diagnosis coding to set rates for hospital outpatient clinic visits could increase disparities in payment methodology between outpatient departments and physician offices, for which a new system of resource based practice costs is just now being proposed. (These concerns do not extend as much to emergent and critical care, which are not routinely furnished in physician office settings.) Diagnostic coding has not been used in the past to adjust payments in the physician office setting and there is no general evidence that practice expense (or work) in physician office settings varies by the patient's diagnosis. Moreover, because patients in the hospital outpatient department can be shifted easily to alternative outpatient settings, adjustment of facility costs to take diagnosis into account in one setting but not others may create incentives to shift patients among ambulatory settings in unknown ways.

Coding Visits

We have considered several approaches to setting prospective payment rates for hospital clinic and emergency visits. We reviewed the medical visit groups in 3M's version 2.0 of APGs that are based solely on ICD–9 diagnosis codes, with 80 APGs providing several groups for each body system; we analyzed the effect on ratesetting of defining clinic and emergency visits solely by CPT code; and, we analyzed the effect of using a matrix that combines patient diagnosis with a CPT code to describe the nature of the outpatient encounter. We discuss these various approaches in more detail here and some of the advantages and disadvantages of each. Again, we solicit comments on these approaches to setting payment rates for clinic and emergency room visits as well as comments on alternative approaches that are not mentioned here.

Approach 1: Using Diagnosis Codes Only

3M's approach of using only ICD–9 diagnosis codes with extensive packaging results in a wide range of group payment rates. The group that pays the most is almost 13 times as costly as the lowest-paid group. However, when we removed minor laboratory tests, x-rays, and certain other minor procedures that had been packaged into 3M's medical visit APGs in order to conform with the packaging that we propose in this proposed rule,

the difference between the highest and the lowest paid group dropped to not quite five times. (Fully packaged APGs are sufficiently differentiated for payment purposes, while partially packaged APGs are not; therefore, if we were to move to a fully packaged system, we would re-evaluate approaches using diagnosis.)

We also found that grouping clinic and emergency visits solely on the basis of diagnoses tends to result in visits that require major resources for critical cases clustering together with less resource-intensive follow-up visits after the crisis has passed.

Approach 2: Using CPT Codes Only

The APC groups that we propose in this proposed rule as the basis for setting rates for surgical services consist solely of CPT codes. We looked at using only CPT codes to establish payment groups for outpatient clinic and emergency room visits, but we found that the variation between the most costly and the least costly encounter was quite flat, with the former only 4.5 times greater than the latter. When basing payment on CPT codes alone, the range reflects hospitals' billing patterns in increasing level of intensity, but cases at the margin are overwhelmed by the numbers of visits billed so that individual cases with low or high costs are not discernible. Also, billing patterns reflect standard bills, not the resources used in any particular case.

Approach 3: CPT and Diagnosis Hybrid

We looked at another approach that bases payment rates on a hybrid of CPT codes and patient diagnoses. We first assigned 31 CPT codes that describe physician encounters with patients in the outpatient setting to seven APC groups: three for clinic visits, three for emergency department visits, and one for critical care. We also collapsed approximately 12,000 ICD–9 codes into 20 major diagnostic categories (MDCs), arranged generally by body system. Classifying services in this fashion produces a more manageable number of groups, and results in a matrix of 121 CPT/diagnosis combinations, in which the most costly combination is more than 10 times as costly as the least.

Our grouping of evaluation and management CPT codes was based on several factors. As we note above, we grouped 31 CPT codes that represent different levels of physician ''evaluation and management'' of patients into seven APC groups. (For a more complete discussion, refer to the evaluation and management services guidelines in Physicians' *Current Procedural Terminology* 1998 edition (CPT '98) published by the American Medical Association.) CPT codes are more descriptive of physician effort than of facility use, and our cost data showed little difference between level 1 and level 2 visits or between level 4 and level 5 visits. Therefore, we elected to combine some of the CPT codes into a single group, for example, the two least intensive outpatient visit codes, 99201 and 99202, are both in APC 911, which is the lowest level of clinic visits, etc. Grouping CPT codes together in this fashion reduces administrative burden, and our data analysis shows only small additional cost differences among the complete set of CPT medical visit codes. Moreover, we found that grouping CPT codes in this fashion evens out certain anomalies that arise when an emergency department furnishes services that would not typically be thought of as emergency care, such as suture removal, or treatment of a skin disease. Even though suture removal or treatment of conditions such as impetigo, conjunctivitis, etc. is performed in emergency departments, these types of services are more appropriately furnished at a clinic because they do not require the more elaborate resources of the emergency department. Assigning codes to APC groups would allow us to set payment for care of patients with minor problems in the emergency department at a level equivalent to payment for the same care when it is furnished at a clinic. We welcome comments on payment for services that do not require emergency room use.

Using a matrix of evaluation and management codes with patient diagnosis would offset the disadvantages noted above of grouping solely by CPT code (too little payment variation) or solely by patient diagnosis (reduced payment variation and commingling of resource intensive and non-resource intensive visits). Defining a clinic or emergency visit APC in terms of both CPT code and diagnosis, even when grouping codes to provide a manageable number of groups, would better recognize the facility resources consumed in providing emergency and critical care visits. Many such visits, of course, cluster around the same dollar amount, but this is expected because many visits involve typical care and standard resources. The cases that represent care at higher or lower levels of intensity appear to represent real differences in resource consumption. We used the CPT/patient diagnosis hybrid to model impacts. We do not believe that payment to individual hospitals would be significantly affected, whether we base payment rates on groups of CPT codes only or on groups that combine CPT codes and patient diagnosis.

Using a matrix that combines CPT codes with patient diagnosis to set payment rates for clinic and emergency department visits would also improve the coding of diagnoses in the hospital outpatient setting generally. Such improved diagnosis coding is critical to evaluating future degrees of packaging in the APC system, and we have already noted that more packaging tends to increase the measured cost differences across APC groups.

However, as we discussed earlier, there are also problems with using a matrix that includes diagnosis codes for hospital outpatient visits. We are concerned about the effect of using a method to pay for clinic visits in the hospital outpatient setting that is at variance with the method we use to pay for the same service in a physician office. A possible alternative to using diagnosis codes as an indicator of resource consumption in connection with medical visits in hospital outpatient departments is to create a uniform fee schedule for physician visits across all ambulatory settings, paying the site at which the service is furnished the physician practice expense component as a ''facility fee.'' However, the latter option would require legislation and a possible reallocation of the overhead currently associated with medical visits in the outpatient department to other outpatient services. Given the complexity of these issues, it may not be desirable to introduce additional differences, such as diagnosis, among payments in medical visits at this time. We invite public comment on all of the issues raised in the discussion in this section. In addition, after this rule is published, we will be reexamining our outpatient database and extending our analysis to multiple visit data. We will incorporate the findings of these additional analyses into our final decision.

Hypothetical Case Using the Hybrid

The following is a hypothetical case presented to illustrate how payment would be determined using the CPT code/diagnosis code hybrid. A new patient, an elderly woman who has recently come to live with her family in the area, presents to the primary care clinic complaining of fatigue, shortness of breath, swollen ankles, and loss of vision. The physician spends 45 minutes eliciting the patient's medical, family, and social history and performing an extensive physical examination. Suspecting cataracts as the

cause of her loss of vision, the physician suggests she make an appointment in the eye clinic. Suspecting congestive heart failure as the cause of her other symptoms, but also suspicious of coexisting diabetes and hypertension, the physician orders laboratory tests and an electrocardiogram (ECG) to be performed that day, and schedules an appointment in the cardiovascular clinic for a later date. If payment to the hospital were to be made on the basis of a CPT code/ICD–9 code matrix, the hospital's claim for services furnished in connection with this visit would identify the following information: CPT code 99204, comprehensive outpatient visit, new patient, and ICD–9 diagnosis code 401.1, benign hypertension. Payment would be determined by mapping CPT code 99204 to APC group 915, levels 4 and 5 clinic visit, and ICD–9 code 4011 to MDC 36, cardiovascular system diseases. Payment would be the rate established for the resulting hybrid group identifier, 91536. Addendum A lists the payment rates for the proposed hospital clinic and emergency room payment groups. Separate payment would be made under the clinical diagnostic laboratory fee schedule for the laboratory work; the ECG would be paid for separately on the basis of the payment rate established for APC 950.

Several months later, the same patient, who now is known to have congestive heart failure, returns to the primary care clinic complaining of a cough and runny nose. The physician, having determined that the symptoms are due to a virus, recommends using a humidifier and drinking extra fluids. The hospital would code this visit with CPT code 99212 (problem-focused outpatient visit, established patient) and with ICD–9 diagnosis code 460 (acute nasopharyngitis, or common cold). This combination, in turn, would map to APC 911, levels 1 and 2 clinic visit, plus MDC 31, ear, nose, mouth and throat diseases, and payment for this patient's second visit to the hospital clinic would be based on the rate established for hybrid group 91131.

Payment for Screening Services

Every patient who presents to an emergency department and requests (or has requested on his or her behalf) a screening must be screened in accordance with section 1867(a) of the Act. If the physician or other hospital staff who performs the screening determines that no medical emergency exists, the patient can be referred to one of the hospital's clinics or to another provider such as a physician office for further treatment, or the emergency department personnel can decide to treat the patient in the emergency department. We propose to create a HCPCS code to be used to bill the screening. Payment for this new code will be low because no treatment is included in the screening. Payment for the screening APC is made only when no additional services are furnished by the emergency department. If non-emergency treatment is furnished, the appropriate emergency room visit should be billed, and *not* the screening. Similarly, if the screening reveals that an emergency does exist and treatment is instituted immediately, the screening should not be billed; the screening is subsumed into the further treatment. If an emergency room physician feels the need to consult with another physician before deciding whether the patient needs emergency treatment, the consultation is part of the original screening, and the hospital should bill for only one screening visit, if a bill for screening is appropriate, as described above.

Payment for Critical Care

We propose to have hospitals use CPT code 99291 to bill for outpatient encounters in which critical care services are furnished. We use the CPT definition of ''critical care,'' which is the evaluation and management of the unstable critically ill or injured patient who requires the constant attendance of a physician. Under the outpatient PPS, we would allow the hospital to use CPT 99291 in place of, but not in addition to, a code for a medical visit or for an emergency department service. However, the entire duration of the hospital outpatient department's critical care services for an individual patient is represented by CPT 99291, and we would not allow the facility to use CPT 99292 to bill for critical care services extended in 30-minute increments, as would the attending physician. (We have packaged the costs associated with subsequent hours of critical care billing into the APG group of services with which the critical care hours were billed in the base year.) If other services, such as surgery, x-rays, or cardiopulmonary resuscitation, are furnished on the same day as the critical care services, we would allow the hospital to bill for them separately.

We expect that the numbering scheme proposed in this rule to distinguish clinic and emergency room visits would be changed in the final rule. Although we believe the 5-digit identifier used in this proposal makes it easier to see the relationship between the CPT code for the level of the visit and the ICD–9–CM code for the diagnosis, for claims processing purposes, we would have to replace 5-digit identifiers with 3-digit ones.

5. Treatment of Partial Hospitalization Services

In accordance with section 1861(ff) of the Act, partial hospitalization services may be furnished only by a hospital to its outpatients or by a community mental health center (CMHC). We published an interim final rule on February 11, 1994 (59 FR 6570) to establish coverage criteria and payment requirements for partial hospitalization programs. In that rule, we indicated that physician services and certain nonphysician practitioner services are not considered to be partial hospitalization services. Payment for these services is outside the scope of this proposed rule.

The partial hospitalization program of services is organized and furnished similarly, whether the program is administered by a hospital or by a CMHC. Section 1833(a)(2)(B) of the Act requires that payment for CMHC partial hospitalization services be based on the hospital outpatient PPS. Thus, the methodology we are proposing would apply to hospital outpatient and to CMHC partial hospitalization programs. The current rules governing CMHC payment appear in 42 CFR part 413. This proposed rule would amend § 413.1 to indicate that payment for partial hospitalization services furnished by CMHCs is made in accordance with the hospital outpatient prospective payment system described in part 419 of this chapter.

Patients eligible for the Medicare partial hospitalization benefit comprise two groups: patients who have been discharged from a psychiatric hospital for whom partial hospitalization services are provided in lieu of continued inpatient treatment; and patients who exhibit disabling psychiatric/psychological symptoms as a result of an acute exacerbation of a severe and persistent mental illness for whom the partial hospitalization services are provided in lieu of admission to an inpatient psychiatric hospital.

As required by section 1835(a)(2) of the Act, admission to a partial hospitalization program is limited to patients whose physicians certify that: (1) the individual would require inpatient psychiatric care in the absence of partial hospitalization services; (2) an individualized, written plan of care has been established by a physician and is reviewed periodically by a physician; and (3) the patient is or was under the care of a physician. This certification would be made when the physician

believes that the course of the patient's current episode of illness would result in psychiatric hospitalization if the partial hospitalization services are not substituted.

The acute psychiatric condition being treated by a partial hospitalization program must require intensive active treatment, including a combination of medical and nursing interventions, individual and group psychotherapy, occupational therapy, family counseling, and various adjunctive therapeutic activities that are not primarily recreational or diversionary. The patient's degree of impairment must be severe enough to require a multidisciplinary structured day program, but not so severe that patients are incapable of participating in and benefitting from an active treatment program. Patients must require partial hospitalization services at levels of intensity and frequency comparable to patients in an inpatient setting for similar psychiatric illnesses. In addition, the patient must have an adequate community-based network to support the patient outside the partial hospitalization program.

Typically, patients admitted to a partial hospitalization program initially require full-time participation in order to provide crisis stabilization, that is, 6 hours of programming for 5 days per week. In some cases, the patient may ultimately require inpatient psychiatric care despite the partial hospitalization services. However, in most cases, as the patient's symptoms diminish and functional goals are achieved, the frequency of attendance is reduced to 4 days and, later, to 3 days. Once the patient's participation drops to this level, the need for partial hospitalization services in lieu of inpatient psychiatric care is not generally indicated and the patient would be discharged to a lower level of outpatient psychiatric care.

Under the current reasonable cost payment system, providers report the total number of units for each partial hospitalization service furnished during the billing period. As noted earlier, hospitals are also required to report claims for services using HCPCS codes. Payment for the additional overhead cost of supportive staff and recordkeeping for a comprehensive day program of services would be built into the provider's charge structure for covered partial hospitalization services and paid through the cost report settlement process.

Because a day of care is the unit that defines the structure and scheduling of partial hospitalization services, we believe that a per diem payment for partial hospitalization services is a more appropriate methodology than billing for each component of a partial hospitalization program. A packaged, per diem approach is used by other governmental and private payers when paying for partial hospitalization services. In order to determine the median cost for the partial hospitalization APC group, we analyzed the components reported for each partial hospitalization service over the course of a billing period and established a per diem payment rate. This analysis resulted in an APC payment rate of $208.25 per day, of which $46.78 is the beneficiary's copayment.

As noted above, partial hospitalization providers currently report the total number of units for each service billed. We have revised the billing instructions to require CMHCs to report HCPCS codes and to require hospitals and CMHCs to report the date of each service, effective October 1, 1998. We welcome information from the public to assist us in refining the median cost for a day of partial hospitalization. We are particularly interested in information concerning the mix of services that constitute a typical partial hospitalization day.

We have not established a group to represent a half-day of partial hospitalization, although we are aware that other governmental and private payers have adopted both a full and half-day rate for partial hospitalization. For example, CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) recognizes a day with at least 6 hours of programming as a full day, while days with at least 3 programmed hours, but less than 6, are paid a per diem rate equal to 75 percent of the full day rate. However, the CHAMPUS per diem is not tied to the cost of certain covered services, but rather to the number of programmed hours the patient attends. As noted above, we will begin to collect information October 1, 1998, regarding which services are furnished each day. Once we have analyzed this information, we will be able to determine the extent to which half-days are used typically in partial hospitalization treatment planning. We are interested in public comments regarding whether we should establish a half-day partial hospitalization group.

We have also decided not to propose a minimum number of hours or units of covered services that constitute a partial hospitalization day at this time. However, we are concerned that a low frequency of participation, either very few days per week or few covered services per day, indicate that the partial hospitalization program is no longer reasonable and necessary and the patient could be managed in a less intensive level of outpatient treatment or periodic office visits. Fiscal intermediaries in performing medical review of claims will continue to make decisions regarding whether the services furnished a patient are covered and payable as partial hospitalization services. As noted above, CHAMPUS has established a minimum of 3 hours of service for payment of their partial hospitalization per diem amount. We are specifically requesting public comment on adopting a minimum number of services for Medicare payment purposes.

We note that many other payers have established an annual limit on the number of covered partial hospitalization days. There is currently no duration limit on the Medicare partial hospitalization benefit. Rather, in order to be covered by Medicare, partial hospitalization services must be reasonably expected to improve or maintain the patient's condition and to prevent relapse or hospitalization. For most psychiatric patients, particularly those with long term, chronic conditions, control of symptoms and maintenance of a functional level to avoid hospitalization is an acceptable expectation of improvement. It is not necessary for a course of partial hospitalization services to have, as its goal, restoration of the patient to the level of functioning exhibited prior to the onset of the illness. Some patients may undergo a course of treatment that increases their level of functioning but then reach a point where further significant improvement is not expected. Continued coverage after this point may be dependent upon evidence that the patient is not able to maintain stability with less intensive treatment. Although we are not proposing a duration standard for partial hospitalization at this time, we are concerned that there is significant variation in duration of treatment. We solicit data that show treatment duration from providers of partial hospitalization services. We are also considering specifying a timeframe for periodic physician recertification of need for partial hospitalization services as a method to ensure that a patient's individual needs continue to require the intensity of a partial hospitalization program.

Finally, we are concerned about the impact of establishing a per diem payment for partial hospitalization on the provision of other outpatient mental health services. Patients should be

referred to the outpatient mental health treatment program that best suits their individual needs. Partial hospitalization programs differ from other outpatient mental health treatment programs in the intensity of the program, the frequency of participation, and the patient's need for a comprehensive structured program of services. Upon discharge from a partial hospitalization program, a patient's symptoms and level of functioning will have stabilized to the point that the intensity of a partial hospitalization program is no longer necessary. We are concerned that providing a per diem payment for partial hospitalization services may discourage timely discharge. For this reason, medical review by fiscal intermediaries will continue to focus on patients' initial and continued eligibility for partial hospitalization services.

As noted previously, once we have complete encounter data on which to base the per diem partial hospitalization rate, the per diem will represent the median cost of services furnished on a typical day. As such, it will not be based on the cost of each service furnished on a particular day. Since partial hospitalization represents the most intensive outpatient program and we will have established the median cost of furnishing a day of partial hospitalization services, it does not seem appropriate to pay more for other, less intensive outpatient psychiatric programs. For this reason, we are specifically requesting public comment on establishing a limit on routine outpatient mental health services furnished on a given day to equal the partial hospitalization per diem amount.

6. Comments on Specific APCs

APCs 061–064. We created separate (that is, unpackaged) groups for various chemotherapeutic agents because we believed that some agents had high costs that would not be recognized if those drugs were packaged into the median cost for the chemotherapy administration. We solicit comment on whether to package these costs into the chemotherapy delivery codes in the final rule. We request that commenters identify high-cost chemotherapeutic agents that would not be adequately recognized if packaged or that may require a separate payment or higher payment grouping.

APC 226: This group represents the facility costs for making custom maxillofacial prosthetics. There are few claims, and the median cost is very low compared to the practice expenses associated with these claims on the Medicare physician fee schedule. We assume poor coding accounts for the anomalous cost. However, it may be that these services are not performed in hospital outpatient departments; they may actually be performed by maxillofacial surgeons in their offices or by dental laboratories. We welcome comments on whether these services are actually provided in the outpatient hospital setting and the resources involved.

APC 317 (Cochlear device implantation): The few claims in our database for this procedure have such disparate costs that we are uncertain of the appropriate assignment of the surgery. The device is paid for from the DMEPOS fee schedule. We solicit comments on whether the implant procedure itself resembles procedures in another APC group to which it could be appropriately assigned.

APCs with a status indicator of ''V'': The groups that represent medical visits in clinics and emergency departments are based on a matrix, with intensity represented by six levels of CPT codes combined with 20 categories of ICD–9 codes indicating diagnosis or condition. Although current instructions require hospitals to use a CPT code to bill for medical visits, we permit hospitals to bill for all medical visits under a single code (99201) unless a hospital chooses to be more specific. In 1997, our data show code 99201 accounting for 22 percent of all medical visits billed, which we surmise is an overstatement of the incidence of the lowest level clinic visit. With the implementation of the hospital outpatient PPS, we will require hospitals to begin coding medical visits with greater specificity. As a result, we expect to see an increase in the relative incidence of higher level medical visits and emergency visits and a proportional decrease in the relative incidence of the lowest level clinic visit. We will monitor claims by provider for unexplained increases in the total number of visits or in the proportion of visits billed at the highest levels. Use of HCPCS codes should conform with the CPT clinical examples of cases in each code level.

Because the layout of the outpatient claim form does not allow a HCPCS code to be linked to more than one ICD–9–CM code, the form properly accounts for only one medical visit per claim. When two or more medical visits occur on the same day for different diagnoses, a separate claim would be created for each visit, showing the appropriate level of CPT code and the related diagnosis. We would expect this to occur only in those hospitals that operate many outpatient clinics dedicated to various conditions, such as a diabetes clinic, arthritis clinic, etc. Clinics in which a patient is seen for one or a number of conditions by one health care professional, such as in a primary care clinic, would bill for only one clinic visit for that encounter.

A medical visit would not be billed simply because a patient has presented to a hospital for a service such as chemotherapy, cardiac rehabilitation, an x-ray, etc.

We propose not to pay for a medical visit that takes place on the same date of service as a scheduled outpatient surgery. Registration of the patient, taking of vital signs, insertion of an IV, preparation for surgery, etc., are packaged into and paid for as part of the APC group to which the surgical procedure or service is classified.

In cases where a surgical procedure or service is performed as the immediate result of an outpatient visit (such as the removal of skin lesions following a visit to a dermatology clinic) or from an emergency department visit, the visit would be billed with a modifier −25, indicating that a separately identifiable evaluation and management service was furnished.

APCs 667 and 668: These groups, for cataract surgery without and with insertion of an IOL, should require different resources, because 667 should not include the cost of an IOL. Because the median costs of the two groups are identical, we assume that hospitals were not correctly coding some cases. Therefore, we have reduced the median cost of 667 by $200 to reflect the resources associated with an IOL. We arrived at this figure by allowing the $150 that was allowed for an IOL as the ASC portion of the blended amount formerly paid, and by assuming that the recognition of hospitals' costs under the blend would result in the hospital IOL ''allowance'' being higher than the ASC's. This reduction will have a very small overall effect, because the services in APC 668 were billed more than 225 times as often as those in APC 667. This also leads us to believe that the data we have for the services in APC 668 are more likely to represent accurate information.

APC 670: This group packages payment for the acquisition costs of corneal tissue with the payment for the corneal transplant surgery. It has been brought to our attention that the costs of acquiring corneal tissue vary widely from one locality to another, so that packaging may not be a reasonable way to handle these costs. We are specifically soliciting comments on the issue of packaging corneal tissue costs. We are also soliciting suggestions for alternate ways to pay for corneal tissue, if the comments and supporting data we

receive indicate that packaging is not an appropriate way to treat these costs.

APCs 761 and 762, and 791 and 792: These groups are anomalous, because the group entitled ''Complex'' in each case has a lower weight than the one entitled ''Standard.'' This has to do with the cost of the procedure itself compared to the cost of the radionuclide involved. We are working with the Society for Nuclear Medicine to correct these anomalies.

APCs 902 and 903: We had very few bills for the vaccines in these groups (902 includes polio vaccine and DPT; 903 includes vaccines for rabies and plague). We are considering combining the two groups. We solicit comments on vaccine costs to supplement our data.

APCs 091 and 91191: Brief psychotherapy encounters can be identified by either a CPT code (as in APC 091) or a low- or mid-level visit with a psychiatric diagnosis (APC 91191). We determined the median costs for these bills taken together, because we believe that there are no differences in the facility resources used in these instances. In the case of other psychiatric encounters, we believe that clinic services at the highest level should be the equivalent of an extended psychotherapy encounter. Mid- and high-level emergency room encounters should be billed by evaluation and management CPT codes and psychiatric diagnoses.

APC 921: Although the addenda refer to this APC, in fact diabetic education services will be paid under the physician fee schedule, which will establish rates for one-on-one sessions and group sessions. The addenda will be corrected in the final rule. (A proposed rule titled ''Medicare Program; Expanded Coverage for Diabetes Outpatient Self-Management Training Services'' is under development.)

APCs 981 and 982: These groups represent nerve and muscle tests. We are continuing to evaluate whether these two groups should be combined in the final rule, because there is very little distinction between them in our cost data.

We are still examining ways to pay for drugs outside the composite rate for ESRD patients, and the services to be paid under our system in CORFs, HHAs, and hospices. These will be APCs, based on services that are packaged in our system.

7. Discounting of Surgical Procedures

Under hospital outpatient PPS, we will discount payment amounts when more than one procedure is performed during a single operative session or when a surgical procedure is terminated prior to completion. The discount policy explained below is consistent with Medicare policy and regulations governing payment for physician and ASC surgical services.

a. Reduced Payment for Multiple Procedures

When more than one surgical procedure (defined as those HCPCS codes in APC groups with status ''T'') is performed during a single operative session, we propose that the full Medicare payment amount and beneficiary copayment amount would be paid for the procedure having the highest APC payment rate. Fifty percent of the normal Medicare payment amount and beneficiary copayment amount would be paid for all other procedures performed during the same operative session to reflect the savings associated with having to prepare the patient only once and the incremental costs associated with anesthesia, operating and recovery room use, and other services required for the second and subsequent procedures.

b. Discounted Payment for Terminated Procedures

Under outpatient PPS, the hospital will use modifiers to indicate procedures that are terminated prior to completion. Modifier-52 (Reduced Services) is used to identify a procedure that is terminated after the patient has been prepared for surgery, including sedation when provided, and taken to the room where the procedure is to be performed, but *before* anesthesia is induced (for example, local, regional block(s), or general anesthesia). Fifty percent of the normal Medicare payment amount and beneficiary copayment amount would be paid for a procedure terminated before anesthesia is induced.

Modifier-53 (Discontinued Procedure) is used to indicate that a surgical procedure was started but discontinued *after* the induction of anesthesia (for example, local, regional block, or general anesthesia), or *after* the procedure was started (incision made, intubation begun, scope inserted) due to extenuating circumstances or circumstances that threatened the well-being of the patient. To recognize the costs incurred by the hospital to prepare the patient for surgery and the resources expended in the operating room and recovery room, the full Medicare payment amount and beneficiary copayment amount would be paid for a procedure that was started but discontinued after the induction of anesthesia or after the procedure was started, as indicated by a modifier-53.

The elective cancellation of procedures would not be reported. If multiple procedures were planned, only the procedure actually initiated would be billed. A pattern of canceled procedures will prompt medical review of the reasons for cancellation and may trigger review of the appropriateness of patient selection for outpatient surgery.

8. Inpatient Care

In recent years, the distinction between inpatient and outpatient care has been blurred by the retention of outpatients in the hospital overnight, sometimes for many days in a row. Medicare paid for observation services while the hospital determined whether an outpatient needed admission for further treatment. Frequently, the patients did not understand that they were not inpatients until they were billed for 20 percent of outpatient charges as copayment. In November 1996, we put in place a policy limiting outpatient observation services to a maximum of 48 hours. We made clear at that time that observation was not a means to make it possible to perform inpatient surgery on an outpatient basis, nor was it appropriate to retain chemotherapy patients in long-term observation. Because observation is not provided as the sole service a patient receives, we packaged costs associated with observation into the median costs for the services, for example, surgery or chemotherapy, with which they were furnished in 1996.

There are procedures that, by their nature, require inpatient care. Open abdominal surgery requires a postoperative recovery period, for example, to ensure that bowel function resumes. Certain major surgeries require monitoring in an intensive care unit until the patient's neurological or other function returns. Yet other surgeries involve large or delicate surgical wounds that require monitoring, skilled dressing changes, and fluid replacement. These procedures obviously require inpatient care, and performing them on an outpatient basis would clearly jeopardize patient health and safety. Other procedures are not as clearly defined as inpatient, but we have classified them as inpatient because they are performed on an inpatient basis virtually all the time for the Medicare population, either because of the invasive nature of the procedures, the need for postoperative care, or the underlying physical condition of the patient who would require such surgery. These procedures are not classified in an outpatient APC group, and no payment is provided for these procedures under the hospital

outpatient PPS. We will deny payment for claims that are submitted for these procedures furnished as outpatient services because performing these procedures on an outpatient basis is not safe or appropriate, and therefore not reasonable and necessary under Medicare rules. Because we base these denials on the exclusion in section 1862(a)(1)(A) of the Act and in § 411.15(k)(1), beneficiaries may be protected from liability by the limitation on liability provision of section 1879 of the Act.

The procedures that we consider appropriate and safe only in an inpatient setting and for which we are excluding payment under the hospital outpatient PPS are listed in Addendum H to enable hospitals to make appropriate site of care decisions. This list represents national Medicare policy and is binding on fiscal intermediaries and peer review organizations, as well as on hospitals and Medicare participating ASCs.

We acknowledge that we have classified in outpatient APC groups some procedures that may seem closely related to procedures that we are excluding from the outpatient PPS on the basis of their status as inpatient procedures. We expect that when the former are performed in the outpatient setting, they will be only the simplest, least intense cases. The fact that a service is included in an APC group under the hospital outpatient PPS should not be construed to mean that the procedure may only be performed in an outpatient setting. In every case, we expect the surgeon and the hospital to assess the risk to the individual patient and to act in that patient's best interests.

C. Calculation of Group Weights and Rates

1. Group Weights

Section 1833(t)(2)(C) of the Act requires the Secretary to develop relative payment weights for covered groups of hospital outpatient services. The statute requires that such weights be developed using 1996 hospital outpatient claims and the most recent available hospital cost reports. We are required to base these weights on median hospital costs. In constructing the database to model the outpatient PPS proposal, we used a universe of approximately 98 million calendar year 1996 final action claims for hospital outpatient department services received through June 1997 to match to the most recent hospital cost reports available.

To derive weights based on median hospital costs for services in the hospital outpatient APC groups, we needed to convert billed charges to costs and aggregate them to the procedure or visit level. To do this, we first identified the cost-to-charge ratio that was specific to each hospital's cost centers (''cost center specific cost-to-charge ratios'' or CCRs). We then developed a crosswalk to match the hospital's CCRs to revenue centers used on the hospital's 1996 outpatient bills. The CCRs included operating and capital costs but excluded costs associated with direct graduate medical education and allied health education. (Medicare payment for direct graduate medical education is made as a pass-through under the inpatient PPS and includes the costs associated with approved educational activities for residents assigned to the hospital's outpatient department. We discuss in elsewhere in this proposed rule how we would make payment for allied health education.)

Our next task was to identify each hospital's most recent available cost report from which to determine the hospital's CCRs. Because there is generally a 2-year lag between claims adjudication and cost report filing, the most recent cost reports that we could expect to be available to associate with calendar year 1996 claims were those from PPS–12 (cost reporting periods beginning on or after October 1, 1994 and before October 1, 1995). We searched the PPS–12 period first to match the 1996 final action claims to a cost report. If we achieved a match, no other action was needed. However, if no match was found, we next searched for a cost report in the PPS–11 period and subsequently in the PPS–10 period, if necessary.

If the most recent available cost report that we used for a provider was one that had been submitted but not settled, we calculated an adjustment factor to adjust for the differences that exist between settled and ''as submitted'' cost reports. We determined the adjustment factor by dividing the outpatient department cost-to-charge ratio from the hospital's most recent settled cost report by the outpatient department cost-to-charge ratio from the hospital's ''as submitted'' cost report for the same period. We used the resulting ratio to adjust each of the CCRs in the hospital's most recent ''as submitted'' cost report. We repeated this process for every hospital for which the most recent available cost report was a cost report that had not been settled.

The Office of Inspector General (OIG) is concerned that the cost reports we are using may reflect some unallowable costs. Therefore, the OIG, in conjunction with HCFA, is proposing to examine the extent to which the cost reports used reflect costs that were inappropriately allowed. If this examination reveals excessive inappropriate costs, we would address this issue in a future proposed rule, or perhaps seek legislation to adjust future payment rates downward.

When this process was completed, we were able to match revenue centers from approximately 83 million claims to CCRs of approximately 5,600 hospitals. We excluded from the crosswalk approximately 15 million claims in which the bill type denoted services that would not be covered under the PPS, for example, bill type 72X for dialysis services for patients with ESRD. The table below shows the three cost reporting periods we used and the percentage of the cost reports within each PPS period with which we were able to match 1996 claims. The most recent cost reports available to us were from the hospital inpatient PPS–12 period, and 95.8 percent of the most recent cost reports available to us matched the 1996 claims that we are required to use as the basis for establishing relative payment weights for the APC groups in the outpatient PPS.

Reporting period	Percentage of cost reports matched
PPS–12 (cost reporting period beginning on or after 10/1/94 and before 10/1/95)	95.8
PPS–11 (cost reporting period beginning on or after 10/1/93 and before 10/1/94)	3.7
PPS–10 (cost reporting period beginning on or after 10/1/92 and before 10/1/93)	0.5
	100.0

We next separated the estimated 83 million claims that we had matched with a cost report into two distinct groups: single-procedure claims and multiple-procedure claims. Single-procedure claims are those for which the HCPCS to be grouped to an APC is the only code that appears on the bill, other than laboratory and incidentals such as venipuncture. Multi-procedure claims included more than one HCPCS code that could be mapped to an APC. There were approximately 37 million single-procedure claims and 46 million multiple-procedure claims.

To calculate median costs for services within an APC, we used only the single-procedure bills. (Of the roughly 37 million single-procedure claims, about 11 million were excluded from the conversion process largely because the only HCPCS codes reported on the claims were for laboratory procedures.)

This approach was taken because of our inability to specifically allocate charges or costs for packaged items and services such as anesthesia, recovery room, drugs, or supplies to a particular procedure when more than one significant procedure or medical visit was billed on a claim. Use of the single-procedure bills minimizes the risk of improperly assigning costs to the wrong procedure or visit. Although single-procedure/visit bills were used for determining APC relative payment weights, the multiple-procedure bills were used in the service mix calculations, regressions, and impact analyses.

For each single-procedure claim, we calculated a cost for every billed line item charge by multiplying each revenue center charge by the appropriate hospital-specific CCR. If the appropriate cost center did not exist for a given hospital, we crosswalked the revenue center to a secondary cost center when possible, or to the hospital's overall cost-to-charge ratio for outpatient department services. We excluded from this calculation all charges associated with HCPCS codes previously defined as noncovered under this PPS, for example, laboratory, ambulance, and therapy services.

To calculate the per-procedure or per-visit costs, we used the charges shown in the revenue centers that contained items integral to performing the procedure or visit. These included those items that we previously discussed as being subject to our proposed packaging provision. For example, in calculating the surgical procedure cost, we included charges for the operating room, treatment rooms, recovery, observation, medical and surgical supplies, blood, pharmacy, anesthesia, cast and splints, and donor tissue, bone, and organ. For medical visit cost estimates, we included charges for items such as medical and surgical supplies, drugs, observation, and blood. A complete listing of the revenue centers we used is included elsewhere in this preamble.

To standardize costs for geographic wage variation, we divided the labor-related portion of the operating and capital costs for each billed item by the hospital inpatient prospective payment system wage index published in the **Federal Register** on May 8, 1998 (63 FR 25575). We used 60 percent to represent our estimate of that portion of costs attributable, on average, to labor, but this factor is sensitive to other payment adjustments. Therefore, we will restandardize costs in the final rule using FY 1999 hospital inpatient PPS wage index values and the final labor market share value. A more detailed discussion of wage index adjustments is found below (section V.E. of this document).

We then added the standardized labor-related cost to the non-labor-related cost component for each billed item to derive the total standardized cost for each procedure or medical visit. We trimmed standardized procedure and visit costs to remove extremely unusual costs that appeared to be errors in the data. The trimming methodology is analogous to that used in calculating the DRG weights for the inpatient PPS: any bills with costs outside of 3 standard deviations from the geometric mean were eliminated. The geometric mean and the associated standard deviation are used because the distribution of costs more closely resembles a lognormal distribution than a normal distribution: there are no negative costs, and the average cost is greater than the median cost. Using the geometric mean has the effect of minimizing the impact of the most unusual bills in the determination of the mean. The geometric mean is calculated by taking the mean of the natural logarithm cost. Since the distribution of the natural logarithms of a set of numbers is more compact than the distribution of the numbers themselves, bills with extreme costs do not appear as extreme as they would if non-logged costs were examined. This ensures that only the most unusual data will be removed from the calculation.

After we trimmed the procedure and visit level costs, we mapped each procedure or visit cost to its assigned APC. We calculated the median cost for each APC weighted by procedure volume.

Using these median APC costs, we then calculated the relative payment weights for each APC. We decided to scale all the relative payment weights to APC 91336, a mid-level clinic visit for cardiovascular services because it is one of the most frequently performed services. This approach is consistent with that used in developing relative value units for the Medicare physician fee schedule. By assigning APC 91336 a relative payment weight of ''1.0,'' hospitals can easily compare the relative relationship of one APC to another. Next, we divided the median cost for each APC by the median cost for APC 91336 to derive the relative payment weight for each APC.

2. Conversion Factor

Section 1833(t)(3)(C)(i) of the Act requires that we establish a conversion factor for 1999 to determine the Medicare amounts for each covered group of services. The statute mandates that the conversion factor be established on the basis of the weights and aggregate projected utilization for 1999 and based on the base amount of payments described in section 1833(t)(3)(A) of the Act. Such base amount is calculated for the services included in the outpatient PPS, as an estimate of the sum of (1) total payments that would be payable from the Trust Fund under the current (non-PPS) payment system in 1999 plus (2) the beneficiary copayments that would have been made under the new (PPS) system in 1999. Section 1833(t)(3)(C)(ii) of the Act further requires that the Medicare amount take into account all appropriate adjustments.

Although section 1833(t)(2)(C) of the Act requires us to project utilization for hospital outpatient services, we were unable to project precisely increases in the volume and intensity of services because we were not able to quantify some of the factors that affect utilization. For instance, we would anticipate that Medicare beneficiaries that choose to migrate to managed care plans may be healthier than those who choose to stay in fee-for-service plans. Thus, we could assume a decrease in the volume of services but an increase in the intensity of services furnished for Medicare beneficiaries enrolled in fee-for-service plans. Another factor that we believe will affect future utilization is the incentive to code HCPCS accurately to receive payment. Currently, hospitals are paid for the majority of the outpatient services they furnish on a cost basis. Claims without a HCPCS or an invalid HCPCS are not always rejected. In contrast, under the new PPS, hospitals would be required to use HCPCS codes and, for medical visits and emergency room services, ICD–9 codes, in order to receive payment. We expect that frequencies may increase as a result of the coding requirements. All in all, these are factors we believe will affect the reporting of volume and intensity of services, but we were not able to quantify these assumptions individually to project 1999 utilization. Therefore, we used what we believe to be a more reliable and valid approach to computing the conversion factor under the methodology described below.

Setting the Rates

In order to convert the relative weights determined for each APC (see previous section) into payment rates, we calculated a conversion factor that would result in payments to hospitals under the PPS in 1999 equaling the total projected payment specified in section 1833(t)(3)(A) of the Act. The prospective payment rate set for each APC is

calculated by multiplying the APC's relative weight by a conversion factor. We computed the conversion factor by first adding together for calendar year 1996 the aggregate Medicare hospital outpatient payments paid under the current cost-based payment system (referred to in this section as current law payments) plus the estimated beneficiary copayment amounts that would be paid under the outpatient PPS for the same services. We then divided that amount by the sum of the relative weights for all APCs under the hospital outpatient PPS. The methodology we followed to determine current law Medicare hospital outpatient payments and beneficiary copayments is discussed in section V.C.2.a., below, which is followed in section V.C.2.b. by a discussion of the sum of the relative weights.

a. Calculating Aggregate Calendar Year 1996 Medicare and Beneficiary Payments for Hospital Outpatient Services (Current Law)

First, to calculate Medicare hospital outpatient payment amounts under current law (that is, before PPS), we identified calendar year 1996 single and multiple procedure bills for all the services that we will recognize under the outpatient PPS. As we identified services that will be paid under the outpatient PPS, we eliminated invalid or noncovered HCPCS codes.

Hospital payments include both operating and capital costs for the HCPCS coded services for which payment is to be made under the outpatient PPS. We summed both of these types of costs by HCPCS at the provider level. Summarizing the data in this manner allows us to simulate provider payment on an aggregate basis. We then applied the legislated capital cost reductions of 10 percent and operating cost reductions of 5.8 percent, as required by section 4522 of the BBA.

We determined for each HCPCS code the applicable payment methodology under current law. We then calculated current law payment for procedures in the baseline using one of the following equations, as appropriate:

- For radiology procedures paid for under the radiology fee schedule, payment is determined in the aggregate for each provider as the lower of cost, charge, or blended amount. The radiology blended amount is determined by the following equation:

(0.42 × lower of cost or charge minus beneficiary copayment) + (0.58 × ((0.62 × global physician fee schedule amount) − beneficiary copayment))

- For surgical procedures for which Medicare pays an ASC facility fee, payment is determined in the aggregate for each provider as the lower of the cost, charge, or blended amount. The ASC blended amount is determined by the following equation:

(0.42 × lower of cost or charge minus beneficiary copayment) + (0.58 × (ASC payment rate − beneficiary copayment))

- For diagnostic procedures paid under the diagnostic fee schedule, payment is determined in the aggregate for each provider as the lower of cost, charge, or blended amount. The blended amount is determined by the following equation:

(0.50 × lower of cost or charge minus beneficiary copayment) + (0.50 × ((0.42 × global physician fee schedule amount) − beneficiary copayment))

For all other covered services not subject to one of the blended payment method categories, payment is determined to be the lower of costs or charges less beneficiary copayment. Because the formula-driven overpayment (FDO) was corrected beginning October 1, 1997, the blended equations eliminate FDO.

We then determined each provider payment. We summed the aggregate amounts computed for each of the four types of payment methodologies discussed above to determine the Medicare payment amount for each provider. In addition, we also determined the amount of the beneficiary copayment for each provider using the beneficiary copayment amounts that would be paid under the PPS. Summing both the Medicare payment and the beneficiary copayment amounts at the provider level is necessary in order to determine the impact of the outpatient PPS on individual hospitals. In addition to calculating provider payments under the current law and PPS payment systems, we calculated the aggregate Medicare payments under the current system and beneficiary copayments under the PPS for all hospitals for services that are within the scope of the outpatient PPS. The total amount reflects the amount hospitals would be paid under the PPS in accordance with section 1833(t)(3)(A) of the Act and is the numerator in the equation for calculating the unadjusted conversion factor.

b. Sum of the Relative Weights

Next we summed the relative weights. Specifically, we multiplied the volume of procedures or visits (excluding the volume of packaged services) for each group by the relative weights for each group. We then calculated the conversion factor by dividing the sum of the volume multiplied by the relative weights for each APC into the total payment explained above, including both Medicare payment and beneficiary copayment. The calendar year 1996 conversion factor is $46.32. To trend forward the 1996 conversion factor to 1999, HCFA's Office of the Actuary estimated an update factor of 1.0939. The update factor represents the estimated per service increase in outpatient Medicare payments and beneficiary copayment between 1996 and 1999 net of changes in the volume and intensity of services. Medicare payments per service were increased by projected CPI-medical items for cost-based services and for blend services mandated updates. Beneficiary copayments were increased by projected increases in CPI-outpatient charges. In estimating the update factor, HCFA's Office of the Actuary assumed that using the national median of the charges for PPS services to establish the unadjusted copayment amount would result in beneficiaries paying 6.9 percent less in coinsurance payments in 1999 than what they would have been expected to pay otherwise, which would create an incentive for a behavioral offset by hospitals of 10 percent of the coinsurance reduction. It was assumed that 45 percent of this offset would apply to the services subject to the PPS and, therefore, would be included in setting the 1999 conversion factor. The remaining 55 percent of the offset would be reflected in expenditures for non-PPS services with both the beneficiary and Medicare absorbing this impact. The adjusted 1999 conversion factor is $50.67.

D. Calculation of Medicare Payment Amount and Copayment Amount

1. Introduction

In the previous section, section V.C, we explain how we determined national prospective payment rates, standardized for area wage variations, for the APC groups. In this section, we explain how we are proposing to calculate Medicare program payment amounts and beneficiary copayment amounts for each APC group.

Under the statutory provision currently in effect, copayment for hospital outpatient department services is based on 20 percent of the hospital's billed charges. Because most hospital outpatient services have been paid, at least in part, on the basis of retrospectively calculated cost, Medicare payment amounts for most

hospital outpatient services are not known at the time the services are furnished. For that reason, coinsurance could not be based on 20 percent of the payment amount. Accordingly, the statute required that copayment be based on 20 percent of charges. Because charges for hospital outpatient services have increased faster than costs for those services, beneficiaries' copayments of 20 percent of charges have, for some services, accounted for 50 percent or more of the total (Medicare program plus beneficiary) payments to the hospitals. Because of extensive secondary insurance coverage, a large share of the copayments made to hospitals is not direct out-of-pocket expenditures by the beneficiaries. There has, however, been concern that premiums for Medigap policies may be affected by the growing copayment liability. In addition, copayments most directly affect those beneficiaries who do not have supplemental insurance. This group of beneficiaries cannot afford to purchase supplemental insurance, and high copayment rates can be a hardship for those needing services. The outpatient PPS created by section 4523 of the BBA, which added section 1833(t) to the Act, includes a mechanism that is designed to eventually achieve a beneficiary copayment level equal to 20 percent of the prospectively determined payment rate that has been established for the service.

MedPAC Comment: In its March 1998 report to the Congress, MedPAC expresses concern about the inequity represented by the current level of beneficiary copayment liability, which generally exceeds 20 percent of the total payment to hospitals for outpatient services. MedPAC, recognizing that immediate beneficiary copayment reductions to 20 percent of payments made to hospitals would result either in unacceptable increases in program outlays and/or unacceptable reductions in payments to hospitals, agrees with the need for a phased-in approach to the copayment reductions. However, MedPAC recommends that the Congress specify a shorter timeframe than that which results from the provisions of the BBA to phase in fully the appropriate beneficiary copayment contribution of 20 percent for hospital outpatient services paid for under the outpatient PPS.

Response: While we do not disagree with MedPAC's recommendation with respect to beneficiary copayment, because of the budgetary implications and the existing statutory requirements resulting from the BBA, implementation of this recommendation would ultimately require action by the Congress.

The next sections describe the steps that we followed in accordance with statutory requirements to determine the beneficiary copayment amount and the Medicare program payment amount for services paid for under the hospital outpatient PPS.

2. Determination of Unadjusted Copayment Amount, Program Payment Percentage, and Copayment Percentage

In order to calculate program payment amounts and beneficiary copayment amounts, we first determined for each APC group two base amounts, in accordance with statutory provisions:

- An *unadjusted copayment amount*, described in section 1833(t)(3)(B) of the Act.
- The ''pre-deductible payment percentage,'' which we call *the program payment percentage*, described in section 1833(t)(3)(E).

The steps that we followed to calculate these two base amounts for each APC group are explained below.

(a) *Calculate the unadjusted copayment amount for each APC group.*

(i) Determine the national median of the charges billed in 1996 for the services that constitute the APC group after standardizing charges for geographic variations attributable to labor costs. (To make the labor adjustment, we divided the portion of each charge that we estimated was attributable to labor costs (60 percent) by the provider's hospital inpatient wage index value, and we added the result to the non-labor portion of the charge (40 percent). Section V.F. provides a detailed discussion of the adjustments made within the outpatient PPS to offset regional differences in labor costs.)

(ii) Update charge values to projected 1999 levels by multiplying the 1996 median charge for the APC group by 29.2 percent, which the HCFA Office of the Actuary estimates to be the rate of growth of charges between 1996 and 1999.

(iii) Multiply the estimated 1999 national median charge for the APC group by 20 percent, which becomes the *unadjusted copayment amount* for the APC group. The *unadjusted copayment amount* is frozen at the 1999 level until such time as the program payment percentage (see below) equals or exceeds 80 percent (section 1833(t)(3)(B)(ii) of the Act).

(b) *Calculate the program payment percentage (pre-deductible payment percentage).* In this proposed rule, we use the term *program payment percentage* to replace the term ''pre-deductible payment percentage,'' which is referred to in section 1833(t)(3)(E) of the Act. The *program payment percentage* is calculated annually for each APC group, until the value of the program payment percentage equals 80 percent. To determine the program payment percentage for each APC group, we followed these steps:

(i) Subtract the APC group's unadjusted copayment amount from the payment rate set for the APC group;

(ii) Divide the difference [(APC payment rate) minus (unadjusted copayment amount)] by the APC payment rate, and multiply by 100. The resulting percentage is the program payment percentage.

Calculation of the program payment percentage allows us to determine a ''copayment percentage,'' which equals the difference between the program payment percentage and 100 percent. As the program payment percentage for an APC group approaches 80 percent due to annual market basket increases of the APC payment rates, the copayment percentage, conversely, approaches 20 percent, which is ultimately the target copayment percentage for all services paid for under the hospital outpatient PPS. When the copayment percentage equals 20 percent of the APC payment rate, we consider the copayment amount for that APC to be fully phased in at the standard Medicare copayment level, as we explain in the next section.

3. Calculation of Medicare Payment Amount and Beneficiary Copayment Amount

a. *Calculate the Medicare payment amount.* A Medicare payment amount is calculated for every APC group. The Medicare payment amount takes into account wage index and other applicable adjustments and applicable beneficiary deductible amounts. The Medicare payment amount calculated for an APC group applies to all the services that are classified within that APC group. The Medicare payment amount for a specific service classified to an APC group under the outpatient PPS is calculated as follows:

(i) Apply to the national payment rate that is set annually for each APC group the appropriate wage index adjustment (see section V.E. for a discussion of how national APC rates are to be adjusted for geographic wage differences) and any other adjustments applicable to the provider;

(ii) Subtract from the adjusted APC group payment rate the amount of any applicable deductible as provided under § 410.160; and

(iii) Multiply the adjusted APC group payment rate, from which the applicable

deductible has been subtracted, by the program payment percentage determined for the APC group or 80 percent, whichever is lower. The result is the Medicare payment amount.

b. *Calculate the copayment amount.*

A *copayment amount* is calculated annually for each APC group. The copayment amount calculated for an APC group applies to all the services that are classified within the APC group. The copayment amount for an APC is calculated as follows:

Subtract the APC group's Medicare payment amount from the adjusted APC group payment rate less deductible, for example, COPAYMENT AMOUNT *equals* [(adjusted APC group payment rate less deductible) *minus* (APC group Medicare payment amount). The resulting difference is the beneficiary copayment amount.

Again, as soon as the Medicare program payment percentage of an adjusted APC payment rate less deductible equals or exceeds 80 percent, we set the copayment amount at 20 percent of the adjusted APC group payment rate, and we consider the standard Medicare 20 percent copayment level to be fully phased in for that APC group (section 1833(t)(3)(B)(ii) of the Act). Thereafter, for those APC groups whose program payment percentage has become 80 percent of the APC payment rate (and whose copayment percentage is 20 percent), the unadjusted copayment amount for the APC ceases to be frozen at the 1999 level. The copayment amount for the APC group is permanently established at 20 percent of the adjusted APC group payment rate. Because the copayment amount is now tied directly to the APC payment rate, the copayment dollar amount increases as annual updates increase the APC group payment rate.

For example, assume that the wage-adjusted payment rate for an APC is $300; the program payment percentage for the APC group is 60 percent; the wage-adjusted copayment amount for the APC group is $120; and the beneficiary has not yet satisfied any portion of his or her annual $100 deductible.

(A) Adjusted APC payment rate: $300
(B) Subtract the applicable deductible: $300 − $100 = $200
(C) Multiply the remainder by the program payment percentage to determine the Medicare payment amount: 0.6 × $200 = $120
(D) Subtract the Medicare payment amount from the adjusted APC payment rate less deductible to determine the copayment amount: $200 − $120 = $80

In this case, the beneficiary pays a deductible of $100 and an $80 copayment. The program also pays $120, for a total payment to the hospital of $300. Applying the program payment percentage ensures that the program and the beneficiary pay the same proportion of payment that they would have paid if no deductible were taken.

In the event that the annual deductible has already been satisfied, the calculation runs as follows:

(A) Adjusted APC payment rate: $300
(B) Subtract the applicable deductible: N/A
(C) Multiply by the program payment percentage to determine the Medicare payment amount: 0.6 × $300 = $180
(D) Subtract the Medicare payment amount from the adjusted APC payment rate less deductible to determine the copayment amount: $300 − $180 = $120

In this case, the beneficiary makes a $120 copayment. The program also pays $180, for a total payment to the hospital of $300.

4. Hospital Election To Offer Reduced Copayment

The transition to the standard Medicare copayment rate (20 percent of the wage-adjusted APC payment rate) will obviously be gradual. For those APC groups for which copayment is currently a relatively high proportion of the total payment, the process will be correspondingly lengthy. Therefore, the Act offers hospitals the option of electing to reduce copayment amounts and allows the hospital to advertise these reduced rates. In this section, we discuss the procedure by which hospitals can elect to offer a reduced copayment amount, and the effect of such election on calculation of the program payment and beneficiary copayment.

Section 1833(t)(5)(B) of the Act requires the Secretary to establish a procedure under which a hospital, before the beginning of a year, may elect to reduce the copayment amount otherwise established for some or all hospital outpatient department services to an amount that is not less than 20 percent of the hospital outpatient prospective payment amount. The statute further provides that the election of a reduced copayment amount will apply without change for the entire year, and that the hospital may advertise its reduced copayment levels. Section 1833(t)(5)(C) of the Act provides that deductibles cannot be waived. Finally, section 1861(v)(1)(T) of the Act (as established by section 4451 of the BBA) provides that no reduction in copayment elected by the hospital under section 1833(t)(5)(B) may be treated as a bad debt.

In this rule, we are proposing that a hospital may make the election to reduce copayments on a calendar year basis. The hospital must notify its fiscal intermediary of its election to reduce copayments no later than 90 days prior to the start of the calendar year. This 90-day notification requirement is necessary in order to give the intermediaries sufficient time to make the systems changes required to implement the hospital's election. The hospital's notification must be in writing. It must specifically identify the APC groups to which the hospital's election will apply and the copayment level (within the limits identified below) that the hospital has selected for each group. The election of reduced copayment must remain in effect unchanged during the year for which the election was made. The hospital may advertise and otherwise disseminate information concerning the reduced level of copayment that it has elected.

We also are proposing that a hospital may elect to reduce the copayment amount for any or all APC groups. A hospital may *not* elect to reduce the copayment amount for some, but not all, services within the same APC group.

A hospital may not elect for an APC group a copayment amount that is less than 20 percent of the adjusted APC payment rate for that hospital. In determining whether to make such an election, hospitals should note that the national copayment amount under this system, based on 20 percent of national median charges for each APC, may yield copayment amounts that are significantly higher or lower than the copayment that the hospital has previously collected. This is because the median of the national charges for an APC group, from which the copayment amount is ultimately derived, may be higher or lower than the hospital's historic charges. We, therefore, advise that hospitals, in determining whether to exercise the option of electing lower copayment and the level at which to make the election, carefully study the annual copayment amounts for each APC group in relation to the copayment amount that the hospital has previously collected.

Calculation of copayment amounts on the basis of a hospital's election of reduced copayment for the most part follows the formula described previously. For example, assume that the adjusted APC payment rate is $300; the program payment percentage for the

APC group is 60 percent; the hospital has elected a $60 adjusted *reduced* copayment amount for the APC group; and the beneficiary has not satisfied the annual deductible.

(A) Adjusted APC payment rate: $300
(B) Subtract the applicable deductible: $300 − $100 = $200
(C) Multiply by the program payment percentage to determine the Medicare payment amount: 0.6 × $200 = $120
(D) Beneficiary's copayment is the difference between the APC payment rate reduced by any deductible amount and the Medicare payment amount, but not to exceed the adjusted reduced copayment amount: $200 − $120 = $80 (limited to $60 because of the hospital-elected reduced copayment amount)

In this case, Medicare makes its regular payment of $120, but the beneficiary pays a $100 deductible and a reduced copayment amount of $60, for a total payment to the hospital of $280 instead of the $300 that the hospital would have received if it had not made its election.

E. Adjustment for Area Wage Differences

1. Proposed Wage Index

Section 1833(t)(2)(D) of the Act requires that, as part of the methodology for determining prospective payments to hospitals for outpatient services, the Secretary must determine a wage adjustment factor to adjust the portion of payment and copayment attributable to labor-related costs for relative differences in labor and labor-related costs across geographic regions in a budget-neutral manner.

To determine which wage adjustment factor to incorporate into the hospital outpatient department PPS, we considered several options. One choice would be to use a wage index specific to hospital outpatient department labor costs. However, the Congress did not require us to nor did we have either the time or resources necessary to construct a hospital-outpatient-department-specific wage index.

We next considered the hospital inpatient PPS wage index that HCFA maintains under the Medicare program. The hospital inpatient PPS wage index is well established, and it is constructed specifically for the purpose of ''reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level'' (section 1886(d)(3)(E) of the Act), a requirement that is analogous to that set forth under the hospital outpatient department PPS in section 1833(t)(2)(D) of the Act. The data upon which the hospital inpatient PPS wage index is based are collected from Medicare cost reports, and the wage index is updated annually. Any changes in hospital inpatient PPS wage index values must be made in such a manner as to assure budget neutrality (section 1886(d)(3)(E) of the Act). The hospital inpatient PPS wage index for fiscal year 1998 reflects the following:

- Total salaries and hours from short-term, acute care hospitals.
- Home office costs and hours.
- Fringe benefits associated with hospital and home office salaries.
- Direct patient care contract labor costs and hours.
- The exclusion of salaries and hours for nonhospital type services such as SNF services, home health services, or other subprovider components that are not subject to the PPS.

A detailed description of the fiscal year 1999 hospital inpatient PPS wage index is contained in the proposed rule entitled ''Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 1999 Rates (HCFA–1003–P)'' published in the **Federal Register** on May 8, 1998 (63 FR 25575).

We decided that using the hospital inpatient PPS wage index as the source of an adjustment factor for geographic wage differences for the hospital outpatient department PPS was both reasonable and logical, given the inseparable, subordinate status of the outpatient department within the hospital overall. We then had to determine which version of the hospital inpatient PPS wage index to use. There are several possible wage indices that can be developed from the basic wage and salary data taken from hospital cost reports, depending on changes that are applied to the data. One modification takes into account the effect of hospital redesignation under 1886(d)(8)(B) of the Act and hospital reclassification under 1886(d)(10). A second modification results from assigning to an urban hospital the statewide rural wage index value for the State in which that hospital is located when the wage index of the urban hospital would otherwise be lower than the statewide rural wage index value (the ''floor''). (In fiscal year 1998, this particular ''hold harmless'' provision affected 128 hospitals in 32 metropolitan statistical areas (MSAs).) Given the choice between the wage index that we use under the hospital inpatient PPS, which reflects reclassification and other changes, and a wage index that does not incorporate these changes, we are proposing to adopt the wage index that is used to determine payments to hospitals under the hospital inpatient PPS to adjust for relative differences in labor and labor-related costs across geographic areas under the hospital outpatient department PPS. We note that hospital outpatient department services do not fall under the category of either ''nonhospital type services'' or of ''other subprovider components,'' which are excluded from consideration in developing the hospital inpatient PPS wage index. We also note that because hospital staff frequently provide services in both the inpatient and outpatient departments, labor costs associated with hospital outpatient department services are generally reflected in the hospital wage and salary data that are the basis of the hospital inpatient PPS wage index.

By statute, we implement the annual updates of the hospital inpatient PPS on a fiscal year basis. However, updates to the hospital outpatient department PPS will be made on a calendar year basis. We are proposing to update the wage index values used to calculate hospital outpatient department PPS Medicare payment and beneficiary copayment amounts on a calendar year basis. In other words, the hospital inpatient PPS wage index values that are updated annually on October 1 will be implemented for the hospital outpatient department PPS on the January 1 immediately following. We are proposing this schedule so that wage index changes are implemented concurrently with any other revisions, such as changes in the APC groups resulting from new or deleted CPT codes, that are implemented on a calendar year basis.

2. Labor-Related Portion of Hospital Outpatient Department PPS Payment Rates

In calculating payments to hospitals under the hospital inpatient PPS, the labor-related portion of expenses within the standardized amounts used to establish the prospective payment rates is multiplied by the hospital wage index value to offset regional wage differences. The fiscal year 1998 labor-related portion under the hospital inpatient PPS is 71.1 percent. The manner in which this portion was calculated is explained in detail in the August 29, 1997 **Federal Register** (62 FR 45993). We note that compensation for wages, salaries, and employee benefits accounts for 61.4 percent of expenses, with the other 9.7 percent attributable to professional fees, postal services, and all other labor-intensive services, as explained in the August 29, 1997 **Federal Register** (62 FR 45995).

Current ASC payment rates are standardized for regional wage differences, and carriers adjust the base rates to calculate payments to individual facilities by multiplying the labor-related portion of the base rate by the appropriate hospital inpatient PPS wage index factor. The labor-related portion of current ASC payment rates is 34.45 percent based on 1986 ASC survey data.

Because of the sequence of steps that we followed to construct the hospital outpatient department services PPS database, we had to estimate the percentage of hospital outpatient department costs attributable to labor in order to standardize hospital outpatient department costs for geographic wage differences. We decided that 60 percent represented a reasonable estimate of outpatient costs attributable to labor, as it falls between the hospital inpatient PPS operating cost labor factor of 71.1 percent and the ASC labor factor of 34.45 percent and is within a percentage point of the labor-related costs under the hospital inpatient operating cost PPS attributed directly to wages, salaries, and employee benefits (61.4 percent) under the rebased 1992 hospital market basket that was used to develop the fiscal year 1997 update factor for inpatient PPS rates (published August 30, 1996 at 61 FR 46187). In addition to considering what percentage of costs is attributed to labor by other payment systems, we considered health care market factors such as the shift of more complex services from the inpatient to the outpatient setting, which could influence labor intensity and costs, and 60 percent seemed appropriate. (As we explain in section V.I. below, regression analysis confirmed the labor percentage to be 60 percent.) We calculated 60 percent of each hospital's total operating and capital costs. We then divided that amount by the provider's 1996 hospital inpatient PPS wage index value to standardize differences in costs that are attributable to geographic wage differences. The total cost of performing a procedure/visit, therefore, includes wage-standardized operating and capital costs, as well as bundled ancillary costs (that is, operating room time, medical/surgical supplies, pharmaceuticals, anesthesia, recovery room, observation, biologicals, etc.) and minor ancillary procedures (for example, venipuncture), as explained in greater detail in section V.C.

The final hospital outpatient department PPS payment rates that would have been effective January 1, 1999 may differ slightly from those proposed in this rule because we intend to adjust APC payment rates using the fiscal year 1999 hospital inpatient PPS wage index values that are implemented October 1, 1998. The hospital inpatient PPS wage index values proposed for fiscal year 1999 are in the **Federal Register** proposed rule published May 8, 1998 entitled ''Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 1999 Rates (HCFA–1003–P)'' (63 FR 25575).

We are proposing to use the annually updated hospital inpatient PPS wage index values to adjust both program payment and copayment amounts for area wage variations, as we explain below.

3. Adjustment of Hospital Outpatient Department PPS Payment and Copayment Amounts for Geographic Wage Variations

To adjust the APC payment rates and beneficiary copayment rates for outpatient services for geographic wage variations, we are proposing to use the same labor-related percentage (60 percent) that we used initially to standardize costs for geographic wage differences. When intermediaries calculate actual payment amounts, they will multiply the prospectively determined APC payment rate and copayment amount by that labor-related percentage to determine the labor-related portion of the base payment and copayment rates that is to be adjusted using the appropriate wage index factor. That labor-related portion will then be multiplied by the hospital's inpatient PPS wage index factor, and the resulting wage-adjusted labor-related portion will be added to the non-labor-related portion, resulting in wage-adjusted payment and copayment rates. The wage-adjusted copayment amount is then subtracted from the wage-adjusted APC payment rate, and the result is the Medicare payment amount for the service or procedure. Note that even if a hospital elects to discount the copayment, the full copayment amount is assumed for purposes of determining Medicare program payments. (See section V.D. for a discussion of how Medicare program payments are calculated when the Part B deductible applies.)

The following is an example of how an intermediary would calculate the Medicare payment for a surgical procedure with a hypothetical APC payment rate of $300 that is performed in the outpatient department of a hospital located in Heartland, USA. The copayment amount for the procedure is $105. The hospital inpatient PPS wage index value for hospitals located in Heartland, USA is 1.0234. The labor-related portion of the base payment rate is $180 ($300 × 60 percent), and the non-labor-related portion of the base payment rate is $120 ($300 × 40 percent). The labor-related portion of the base copayment rate is $72 ($120 × 60 percent), and the non-labor-related portion of the base copayment rate is $48 ($120 × 40 percent). It is assumed that the beneficiary deductible has been met.

Wage-Adjusted Base Payment Rate (rounded to nearest dollar):
= ($180 × 1.0234) + $120
= $184 + $120
= $304

Wage-Adjusted Base Copayment Rate (rounded to nearest dollar):
= ($72 × 1.0234) + $48
= $74 + $48
= $122

Calculate Medicare Program Payment Amount:
$304 − $122 = $182

F. Claims Submission and Processing

Hospitals will receive detailed instructions on claims submission over the coming year. This section provides a brief overview of the process.

In order for APCs to properly capture services furnished, hospitals must assign HCPCS codes to services. Revenue center codes will capture only packaged services (operating and recovery room, pharmaceuticals, medical/surgical supplies, etc.). Correct assignment of codes requires an understanding of the differences among surgical procedures, a knowledge of the extent of effort expended in a clinic visit, etc. We believe that many hospitals currently have surgical records coded using HCPCS in the medical records department. However, many hospital coders are much more familiar with the ICD–9–CM system of classification than they are with HCPCS. Among the sources of education available to update skills, hospitals may want to explore in-service education from a credentialed coder with experience in billing for physicians' and surgeons' services, classes available from local hospital associations or medical record associations, formal classes in local colleges, etc.

Coding conventions in the outpatient setting differ slightly from those in use in inpatient settings. The diagnosis identified on the claim need not be the ''principal'' diagnosis, as required under DRGs. Instead the diagnosis is the reason for the visit as identified at the time of the visit. It is not necessary to wait to submit the claim until laboratory or x-ray results are known, in an effort to more clearly identify the diagnosis. In billing for clinic and emergency

department visits, the diagnosis should relate to the reason for the visit. A patient who attends several different clinics in one day should have separate claims submitted for each clinic visit, since at this time only one diagnosis can be associated with each claim. We will seek a change to the UB–92 allowing diagnoses to be identified by number, so that each line item can have a diagnosis associated with it.

Another difference from inpatient reporting is that the DRG GROUPER can take every procedure coded and identify the one highest in the surgical hierarchy applicable to the diagnosis, then ignore those that do not affect the DRG. The HCPCS codes, however, are both more numerous and very specific and should be used appropriately, since each code will trigger a payment.

We propose to apply to hospital outpatient claims HCFA's Correct Coding Initiative (CCI). One of the purposes of the CCI is to ensure that the most comprehensive of a group of codes is billed instead of the component parts. For example, G0001 (routine venipuncture) is a component part of 36430 (transfusion of blood or blood components) and should not be separately billed. Similarly, 94760 (pulse oximetry) should not be billed with surgical procedures for which it is a common monitoring technique. In 1997, hospital outpatient claims showed it more than 10,000 times with 45378 (diagnostic colonoscopy). The CCI also checks for mutually-exclusive code pairs. For example, 93797 (cardiac rehabilitation without ECG monitoring) should not be billed simultaneously with 93798 (cardiac rehabilitation with ECG monitoring), which happened nearly 12,000 times in 1997 hospital outpatient claims. We propose to use the CCI edits to ensure that only appropriate codes are grouped and priced.

Carriers have used CCI as an editing tool since January 1996, and have discovered that the vast majority of edits are rarely triggered. However, as shown in the examples above, hospitals' coding patterns could result in inappropriate payments unless such edits are applied. Under the cost reimbursement system, these types of errors did not ultimately result in higher payments to the hospitals; nor did providing wrong numbers in the units field (for example, repeating the revenue code). Again, under this PPS, each unit billed will trigger a payment. Thus, we have created a second set of edits limiting the number of units allowed for each HCPCS code. For example, only ''1'' will be accepted in the units field for cataract surgery, but for most services the edit allows for the procedure to be performed a number of times in a day, with an upper limit to reduce obvious errors. Of course, hospitals should report only the actual number of times a procedure was performed, keeping in mind that CPT and HCPCS definitions sometimes specify the units. For example, code 11720 is for debridement of nail(s) by any method; one to five. This code should be reported only once for any number of nails debrided between one and five, inclusive. If more than five nails are debrided, the appropriate code is 11721, debridement of nail(s) by any method; six or more, billed only once in place of 11720.

We propose to require that hospital outpatient and CMHC bills that span more than one day indicate the date of the service for each line item on the bill. Line item dates of service are needed in order to implement the CCI and the units' edits, both of which are applied based on services furnished on the same date.

Further information on billing line item dates of service, using HCPCS to code all claims, and editing will be provided by instructions.

G. Updates

1. Revisions to Weights and the Wage and Other Adjustments

Section 1833(t)(6)(A) of the Act gives the Secretary authority to periodically review and update the APC groups, the relative payment weights, and the wage and the other adjustments that are components of the outpatient PPS, to take into account changes in medical practice, changes in technology, the addition of new services, new cost data, and other relevant information and factors.

We explained above that we intend to update the wage index values used to calculate program payment and copayment amounts on a calendar year basis, adopting effective for services furnished each January 1 the wage index value established for a hospital under the inpatient PPS the previous October 1.

Recalibration of the APC group weights is another type of revision provided for under the statutory review authority. We define recalibration as the updating of all the APC group weights based on more recent information. We do not intend to make this type of update on an annual basis. For example, we are required to rebase ASC payment rates using survey data that are collected every 5 years. At this time, we would like to solicit comments on how frequently to recalibrate the hospital outpatient APC weights and on the method and data that should be used.

Section 1833(t)(6)(B) of the Act requires that all revisions to APC groupings, weights, and other adjustments be made in a budget-neutral manner. Adjustments made for a particular year may not cause the estimated amount of expenditures under the outpatient PPS to increase or decrease from the expenditures that we estimate would have been made under the outpatient PPS without any updates or revisions.

2. Revisions to APC Groups

It is our intent to use the same APC surgical groups in the payment systems both for hospital outpatient services and for surgical services furnished by Medicare-approved ASCs. A discussion of the use of APC groups to set payment rates for Medicare-approved ASCs can be found in the proposed rule entitled ''Update of Ratesetting Methodology, Payment Rates, Payment Policies, and the List of Covered Surgical Procedures for Ambulatory Surgical Centers Effective October 1, 1998'' (HCFA–1885–P) that was published in the **Federal Register** June 12, 1998 (63 FR 32290). In order to maintain comparability of the APC groups across both settings, we are proposing to coordinate our review of comments on the composition of the APC groups that are submitted during the public comment period following publication of both this proposed rule and the ASC proposed rule. We are further proposing to coordinate any adjustments to the composition of the APC surgical groups that may result from our analysis of both sets of comments to ensure that the final APC surgical groups not only reflect and take into account both sets of comments, but also remain comparable for ASCs and hospital outpatient departments to the maximum extent possible within the constraints imposed by statutory and regulatory requirements.

Thereafter, we expect the composition of all the APC groups to remain essentially intact from one year to the next with the exception of the few changes that may be necessary as a consequence of annual revisions to HCPCS and ICD–9 codes. We do not plan to routinely reclassify services and procedures from one APC to another. HCFA will make these changes based on evidence that a reassignment would improve the group(s) either clinically or with respect to resource consumption. All changes in APC groups must be budget neutral, and changes in APC groups will only be made through notice and comment when we implement the annual outpatient PPS update.

We are proposing to follow certain conventions when, as a result of annual HCPCS and ICD–9 revisions, we add new services to the hospital outpatient PPS. As part of the notice and comment process accompanying the annual update of the outpatient PPS, we shall propose the assignment of a newly created code to the existing APC that, in the judgment of our medical advisors, is the most similar clinically and in terms of resource requirements to the new service. Because a new service will not have any charge history or cost data associated with it, classification of a new service to an existing APC group will not alter the APC payment rate, relative weight, and program payment and copayment amounts that have been established for that APC group. The new service will assume the same payment rate, relative weight, and program and copayment amounts that have been established for the APC group to which it is classified.

If the annual revision of HCPCS or ICD–9 result in the deletion of a code or service that is classified in an APC group under the outpatient PPS, we shall remove that service from the APC group and discontinue paying for the service under the outpatient PPS. When a CPT code that contributed cost data to our 1996 database is deleted, we will continue to use the cost data in the APC. This in fact did occur in the psychotherapy set of codes. The codes that were in effect in 1996 have been replaced. If we did not capture these data from those codes, we would not be able to assign a weight to brief psychotherapy visits. As long as the new codes belong in the same APC, in terms of clinical coherence and related resource use, the data are relevant. If the code that contributed data to the 1996 database were revised so that it no longer belonged in the APC to which it was originally assigned, the revised code would be placed in an APC that better matched the new description. As in the case of an entirely new code, no cost data would be available for the revised code, so it would be assigned the weight, program payment rate, and copayment rate of the codes in the new APC. We will not create an APC for an entirely new code, but will assign it for at least 2 years to an existing group while accumulating data on its costs relative to the other codes in the APC.

When we do reclassify a service from one APC group to another, the reclassification will affect the payment rate, the weight, and the payment and copayment amounts for both of the ''donor'' APC group and the ''receiving'' APC group if the service that is reclassified was recognized in 1996 and is reflected in our database. As a result of reclassifying a service that was recognized in 1996 and is reflected in our database, we shall recalculate the payment rate, the weight, and the payment and copayment amounts for both the ''donor'' APC group and the APC group to which the service is reassigned. If the service that is reclassified was not recognized in 1996 and is therefore not reflected in our database, we shall treat it in the same manner that we treat the addition of altogether new services and the removal of services that are deleted from HCPCS and ICD–9, that is, reclassifying the code will have no effect on the payment rate, relative weight, and payment and copayment amounts for either the donor APC or the receiving APC, and the reclassified code will assume the payment rate, relative weight, and payment and copayment amounts of the APC to which the service is reclassified.

3. Annual Update to Conversion Factor

Section 1833(t)(3)(C)(ii) of the Act requires us to update annually the conversion factor used to determine APC payment rates. Section 1833(t)(3)(C)(iii) of the Act provides that the update be equal to the hospital inpatient market basket percentage increase applicable to hospital discharges under section 1886(b)(3)(B)(iii) of the Act, reduced by one percentage point for the years 2000, 2001, and 2002. We also have the option (under section 1833(t)(3)(C)(iii)) of developing a market basket that is specific to hospital outpatient services. We are considering this option, and we solicit comments on possible sources of data that are suitable for constructing a market basket specific to hospital outpatient services.

H. Outlier Payments

Section 1833(t)(2)(E) of the Act requires us to establish in a budget-neutral manner other adjustments that we determine are necessary to ensure equitable payments, such as outlier adjustments or adjustments for certain classes of hospitals. We considered several factors to evaluate the necessity of an outlier adjustment policy.

The most relevant factor is that the proposed system has minimal packaging. Unlike the DRG system for inpatient services, where a patient can be classified into only one payment group during an inpatient stay, payment can be made for a number of APC groups for a given patient on a given day. If multiple services are delivered, payments will be made for multiple APCs. Because a hospital will receive payment for each service furnished, we believe this greatly reduces the need for an outlier adjustment.

Another relevant factor is that critical care services have been isolated into their own APC. Payment for the critical care APC is based on median hospital costs of critical care services. Therefore, payments for this group will reflect the intensity and associated higher costs of this type of medical care.

Even if critical care is not delivered, higher payment will be made for more serious cases. Payments for medical visits to the emergency room will be made at three incremental levels of intensity, and additional payments will be made for any other laboratory work, x-rays, or surgical interventions resulting from the visit.

Upon consideration of the above factors, we do not believe that an outlier adjustment is necessary to ensure equitable payments.

I. Adjustments for Specific Classes of Hospitals

As part of the analysis to determine whether payment adjustments would be proposed for the outpatient prospective payment system, we conducted extensive regression analysis of the relationship between outpatient hospital costs (calculated as hospital outpatient operating and capital cost per unit) and several factors that affect costs. The latter included variables used in estimating similar models for the inpatient PPS, as well as several variables unique to hospital outpatient departments. We considered all costs and services for each hospital relevant to the proposed payment system. Ultimately, we decided not to propose any adjustments to the Federal payment other than the wage index used to adjust for local variation in labor costs at this time. While this reflects a difference in policy relative to inpatient PPS, the proposed outpatient PPS is fundamentally different. Specifically, the outpatient system has limited packaging, so variations in costs are limited to the resources used to produce a single procedure. Cost variations in the inpatient system, however, also can be attributed to variation in the intensity of services bundled under a single rate. Therefore, variations in outpatient cost per unit among hospitals are expected to be small relative to the variations in inpatient cost per discharge that have been estimated in the past.

We began our analysis by examining the distribution of service mix and cost per unit (or cost per service) among various types of hospitals. This analysis revealed some extreme values of cost per unit among types of hospitals, especially major teaching hospitals,

hospitals with trauma centers, and eye and ear hospitals. These costs were 200 percent to 400 percent higher than the average cost per unit for all hospitals. Because costs are measured on a per unit basis, values of this magnitude suggested problems both with identifying procedure codes and properly entering the correct unit of measurement (times performed, minutes of treatment, etc.). Under the current payment system, hospitals will be fully reimbursed for their services even if claims do not contain all the procedure codes that would be associated with revenue centers billed. A consistent practice of such under-coding would lead to very high costs associated with a single unit.

The presence of these extreme values also suggested that a few hospitals could unduly influence the distribution of hospital outpatient cost per unit in our regression analysis. Individual bills were not edited for extreme unit costs. However, even removing cost outliers at the bill-level might not have eliminated these extreme variations at the hospital level. A single under-coded bill might not meet outlier thresholds, but the combined effects of coding differences on all of a hospital's bills could create much higher or lower unit costs.

In light of the lack of trimming for outlier/error costs at the bill level, the possibility of outlier hospitals skewing the distribution of cost per unit, and the hospital-level analysis for payment adjustments argued for an edit on cost per unit at the hospital level. The distribution of cost per unit more closely resembles a lognormal distribution than a normal distribution; there are no negative costs and the average cost is greater than the median cost. We identified outliers using the mean and standard deviation of the natural logarithm of cost per unit. Taking the natural logarithm of any variable compresses the distribution and minimizes the impact of the most unusual bills in the determination of the mean. The compressed distribution also makes it more difficult to identify outliers.

We removed 83 hospitals through an edit of three standard deviations from the mean of the logged unit costs: 51 hospitals with a logged cost per unit exceeding three standard deviations above the mean and 32 hospitals with a logged cost per unit less than three standard deviations below the mean. Removing outlier hospitals greatly improved the distribution of unit costs among types of hospitals. The exempted Maryland hospitals were also excluded from the analysis. However, we included the 10 cancer hospitals. After we removed the 54 exempted Maryland hospitals, outlier hospitals, and hospitals for which we could not identify payment variables, we were left with 5,419 hospitals for analysis. Our regression analyses use this set of hospitals.

A variety of regression models have become the standard of practice for examining hospital cost variation and analyzing potential payment adjustments. We looked at two standard models: fully specified explanatory models to examine the impact of all relevant factors that might potentially affect outpatient hospital cost per unit and payment models that examine the impacts of those factors used to determine payment rates. The payment models standardize the dependent variable, hospital outpatient cost per unit, by service mix to capture the relationship between the APC weights and payment under the PPS, rather than a statistical relationship between service mix and costs. Both unweighted regressions and regressions weighted by volume were examined. All regressions employed a double log or semi-log specification. References to logs throughout this discussion refer to the natural logarithm, and the geometric mean is the mean of the natural logarithm of values. Our dependent variable was total hospital outpatient cost per unit.

We used payment variables from the inpatient prospective payment system, including disproportionate share patient percentage, both capital and operating teaching variables (resident to average daily census and resident to bed ratios respectively), and dummy variables to account for location in a rural, large urban, and other urban area. We also looked at a modified teaching variable that reflects outpatient volume, several dummy variables unique to outpatient departments, such as the presence of a trauma unit, and the difference in costs among various types of TEFRA hospitals and cancer hospitals. A discussion of the major payment variables and our findings appears below.

Service Mix Index

Using APC weights and the number of services provided in each APC, we calculated an average APC weight, or service mix, for each hospital. We also calculated a ''discounted'' service mix that considers the reduced weight for additional surgical procedures performed at the same time, which is consistent with the proposed payment system. The national average service mix is 1.43, and the national average service mix discounted for multiple procedures is 1.45. The differences between the two are negligible due to the low volume of services subject to discounting, and they proved almost interchangeable in the adjustment regressions. We did use the discounted service mix for our regressions because it reflects the proposed policy.

Since APC weights are calculated from costs, we would expect approximately a one to one, or proportional, relationship between service mix and hospital outpatient cost per unit. That is, we expect the coefficient of the service mix to be one in a regression of outpatient cost per unit on the service mix. However, initial payment regressions of hospital outpatient cost per unit on service mix and the wage index revealed a coefficient of 0.68, suggesting that the calculated service mix increases faster than cost per unit; a 10 percent increase in the service mix is associated with a 6.8 percent increase in costs.

This estimated relationship prompted a preliminary analysis of the relationship between geometric means and median cost per unit within each APC. If per unit cost within APCs is distributed log normally, the median and the geometric mean are equivalent. However, if the distribution of costs within APCs is skewed, then the median may differ from the geometric mean. Because the dependent variable in the regression models is the natural log of hospital outpatient cost per unit, a systematic difference between the geometric mean of cost per unit and median cost per unit could explain the lack of one to one relationship between hospital service mix and hospital cost per service. Weighting the regression equation by the volume of services, essentially giving greater weight to the relationship between service mix and unit costs for hospitals with a higher volume of services, increases the relationship to 7.5 percent. Higher volume hospitals tend to have a higher service mix and higher service costs.

A limited analysis of unit costs for selected APCs demonstrated that, in general, in APCs with low relative weights, median hospital cost per unit is lower than the geometric mean of logged hospital cost per unit, and, in APCs with high relative weights, median hospital cost per unit is generally higher than the geometric mean. This would lead to a greater spread in a hospital's service mix than appears in their actual cost per unit, and would provide an explanation for the less than proportional relationship that was estimated to exist between service mix and cost per unit. A regression of cost per unit on a service mix derived from weights based on the geometric

mean and the wage index demonstrated better correlation; a 10 percent increase in service mix led to a 7.7 percent increase in cost per unit. Weighting this regression equation by the volume of services increases the relationship to 9.1 percent, suggesting that the higher service mix of higher volume hospitals better tracks those hospitals' cost per unit.

Labor Share

The coefficient of the hospital wage index is the estimated percentage change in costs attributable to a 1 percent increase in the wage index. This coefficient provides an estimate of the share of outpatient hospital unit costs that are attributable to labor. Depending on the model specification, the coefficient ranged from 0.51 to 0.68 reflecting a labor share between 50 and 70 percent. The coefficient from a fully specified payment regression of the hospital cost per unit standardized for the service mix on the wage index, disproportionate share patient percentage, modified teaching, rural, and urban variables is approximately 0.60, suggesting a labor share of 60 percent. Even though we ultimately decided that we would not propose additional adjustments, we believe that the coefficient from this specification provides the best estimate of the labor share for the proposed system. This judgment was based on a policy to use a labor share that reflected the relationship between the wage index and costs, rather than the effects of correlated factors. The explanatory regression model that has a dependent variable of unstandardized hospital outpatient cost per unit also implies a labor share of 60 percent across most specifications.

Teaching Intensity and Disproportionate Share Patient Percentage

For the inpatient PPS, the intensity of teaching programs has typically been measured by the resident to bed ratio or resident to average daily census ratio. Early in our regression analysis, we used resident to the average daily census of inpatient days, the teaching variable from inpatient capital PPS. The results suggested that costs increase somewhat with the size of the teaching program ($p<0.05$). However, we believed that this ratio could not adequately represent teaching hospitals with large outpatient departments relative to the size of their inpatient operations. We modified the resident to average daily census variable to reflect the ratio of residents to combined inpatient and outpatient utilization. To accomplish this, we calculated the ratio of inpatient costs per day to outpatient costs per unit for each hospital, and we used this ratio to convert hospital services into inpatient day equivalents. We combined both inpatient days and outpatient day equivalents to get a ratio of residents to inpatient and outpatient days. Since we cannot, at this time, allocate residents to inpatient and outpatient settings, we could not estimate a teaching variable based on residents to outpatient volume alone.

We created the disproportionate share patient percentage variable by adding the percentage of inpatient days attributable to Medicaid patients to the percentage of Medicare patients receiving Supplemental Security Income. In most regression specifications, the disproportionate share percentage was positive, small in magnitude, and significant ($p<0.05$). These coefficients imply that a hospital with a 40 percent disproportionate share percentage would be approximately 4.5 percent [calculated $(e^{(DSHP*0.11}-1)*100$] more costly than hospitals without any low-income patients. Teaching intensity variables were not significant in un-weighted regressions ($p>0.05$). However, they were positive and significant in regressions weighted by number of services. The teaching coefficient implies that a hospital with a resident to combined inpatient and outpatient ''days'' ratio of 0.35 would be 2.4 percent [calculated $((1+IME)^{0.08}-1)*100$] more costly than hospitals with no residents.

We also estimated several regression specifications to determine if there were thresholds for the estimated impacts of teaching and disproportionate share patient percentage on costs. We determined that positive and significant estimated differences do not occur for hospitals whose disproportionate share percentage is less than 0.40. Significant effects for the teaching variable do not occur for hospitals whose ratio of residents to inpatient and outpatient days is less than 0.32. We used these results to estimate a new disproportionate share patient percentage based on a 0.30 threshold and a ratio of residents to inpatient and outpatient ''days'' based on a 0.28 threshold. We chose these thresholds by identifying the point at which the relationship between the unit costs and the teaching intensity or disproportionate share patient percentage becomes positive rather than significant because of the lack of significance associated with the teaching variable and because the small coefficient for the disproportionate share variable led to intermittent significance for higher values. We subtracted these thresholds from the original variable to create new teaching and disproportionate share patient percentage variables. Subtracting the threshold removes the effect of values that are not significantly related to cost per unit and eliminates the sudden increase (notch effect) in the disproportionate share patient percentage and teaching variable at the threshold level. The new variables suggest that a hospital with a disproportionate share patient percentage 10 points higher than the 30 percent threshold is approximately 2.3 percent more costly [calculated $(e^{DSHP*0.23}-1)*100$] and that a hospital with a ratio of residents to inpatient and outpatient utilization 0.07 higher than the 0.28 threshold is approximately 0.75 percent more costly [calculated $((1+IME)^{0.11}-1)*100$].

Urban and Rural Location

We also estimated difference in hospital outpatient costs between rural, large urban, and other urban areas. In almost all of the regression models, both explanatory and payment, the rural dummy variable was positive and significant ($p<0.05$). Rural hospitals had approximately 8 percent higher standardized unit costs than urban hospitals. In all of the regression models, large urban hospitals were not significantly different from other urban hospitals.

TEFRA and Cancer Hospitals

We also found that some types of TEFRA hospitals (long-term care, children's, and psychiatric) and the ten cancer hospitals have significantly ($p<0.05$) higher unit costs standardized for service mix. Cancer, children's, and long term care hospitals demonstrated standardized unit costs that were at least 20 percent higher than other hospitals. We believe that these significantly higher costs largely can be attributed to under-coding because proper coding is not required for the payment of many services under the current system, especially medical visits. Poor coding would affect calculations of both service mix and cost per unit.

Estimated Payments

The appropriateness of potential payment adjustments must be based on both cost effects estimated by regression analysis and other factors including simulated payment impacts. We simulated the impact of the proposed system on hospitals by calculating the percentage difference between payments made under current law and payments

under the proposed system (column 3). Section X. contains a more complete table that considers the impact of proposed payments on additional classes of hospitals, including TEFRA and cancer hospitals. Although Column 3 represents the net effect of the new PPS on hospitals, we thought it was necessary to show the impacts on hospitals of simply changing the payment system without including the effects of the overall reduced payment to hospitals because the PPS system is not budget neutral to current payment. To reiterate, the conversion factor is set by summing Medicare payments under the current system and beneficiary copayment under the new system and dividing by the sum of the relative weights. Beneficiary copayments under the new system will reduce overall payments to most hospitals because 20 percent of the median group charges is less than 20 percent of actual charges. Therefore, we simulated the impacts as though the conversion factor were set as if the system were to be budget neutral. Column 4 demonstrates the distributional impacts resulting from implementing the new system after eliminating the overall reduction in payment most hospitals will experience due to the effect of the methodology used to set the conversion factor. We believe the column 4 percentage differences are what we should examine since any adjustment we would consider should correct for inequities caused by moving to a PPS (not the legislated reduction in total payment). Therefore, we based our decision about adjustments on these percentage differences rather than percentages combining the PPS and the overall reduction in coinsurance amounts required by law. We also estimated payment to cost ratios associated with the new payment methods and the percent change in total Medicare payments. All simulations used a labor share of 60 percent. The table below shows the results of two simulations. The first contains only the wage index adjustment to the APC rates. The second also includes the threshold adjustments for disproportionate share patient percentage and teaching intensity discussed above.

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CHANGES FOR 1999
OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

			No Teaching and DSH Adjustments				Teaching and DSH Adjustments			
	Number of hospitals (1)	Outpatient percent (2)	Percent change in Medicare Outpatient payment (3)	Conversion Factor Effect removed (4)	Stand-ardized payment to cost ratio (5)	Percent change in total Medicare payments (6)	Percent change in Medicare Outpatient payment (7)	Conversion Factor Effect removed (8)	Standardized payment to cost ratio (9)	Percent change in total Medicare payments (10)
ALL HOSPITALS	5,419	9.9	-3.8	-0.0	1.0000	-0.4	-3.8	-0.0	1.0000	-0.4
NON-TEFRA HOSPITALS	4,864	10.0	-3.7	0.1	1.0011	-0.4	-3.7	0.1	1.0012	-0.4
GEOGRAPHIC LOCATION: URBAN HOSPITALS	2,677	9.3	-3.3	0.5	1.0057	-0.3	-3.2	0.6	1.0069	-0.3
LARGE URBAN AREAS	1,516	9.1	-5.0	-1.3	0.9868	-0.5	-4.6	-0.8	0.9915	-0.4
OTHER URBAN AREAS	1,161	9.6	-0.9	3.0	1.0332	-0.1	-1.3	2.6	1.0293	-0.1
RURAL HOSPITALS	2,187	14.7	-5.2	-1.5	0.9816	-0.8	-5.7	-1.9	0.9770	-0.8
VOLUME (URBAN)										
0- 4,999 UNITS	278	12.1	-15.6	-12.3	0.8164	-1.9	-14.8	-11.4	0.8244	-1.8
5,000- 10,999 UNITS	442	9.8	-6.3	-2.6	0.9559	-0.6	-5.8	-2.1	0.9607	-0.6
11,000- 20,999 UNITS	599	9.1	-5.8	-2.1	0.9574	-0.5	-5.6	-1.9	0.9593	-0.5
21,000- 42,999 UNITS	780	8.7	-3.6	0.2	1.0071	-0.3	-3.9	-0.1	1.0040	-0.3
43,000 OR MORE UNITS	578	9.7	-2.0	1.9	1.0266	-0.2	-1.7	2.2	1.0299	-0.2
VOLUME (RURAL)										
0- 4,999 UNITS	816	18.2	-17.0	-13.7	0.7799	-3.1	-17.2	-13.9	0.7781	-3.1
5,000 - 10,999 UNITS	694	15.8	-10.0	-6.5	0.9144	-1.6	-10.3	-6.7	0.9122	-1.6
11,000 - 20,999 UNITS	420	14.6	-5.8	-2.1	0.9848	-0.8	-6.2	-2.5	0.9812	-0.9
21,000- 42,999 UNITS	215	13.5	-1.8	2.0	1.0368	-0.2	-2.5	1.3	1.0294	-0.3
43,000 OR MORE UNITS	42	13.2	5.3	9.4	1.1263	0.7	4.6	8.7	1.1190	0.6

	Number of hospitals (1)	Outpatient percent (2)	No Teaching and DSH Adjustments: Percent change in Medicare Outpatient payment (3)	No Teaching and DSH Adjustments: Conversion Factor Effect removed (4)	No Teaching and DSH Adjustments: Stand-ardized payment to cost ratio (5)	No Teaching and DSH Adjustments: Percent change in total Medicare payments (6)	Teaching and DSH Adjustments: Percent change in Medicare Outpatient payment (7)	Teaching and DSH Adjustments: Conversion Factor Effect removed (8)	Teaching and DSH Adjustments: Standardized payment to cost ratio (9)	Teaching and DSH Adjustments: Percent change in total Medicare payments (10)
TEACHING STATUS										
NON-TEACHING	3,847	11.2	-3.1	0.7	1.0031	-0.3	-3.7	0.1	0.9973	-0.4
FEWER THAN 100 RESIDENTS	766	9.1	-1.8	2.0	1.0326	-0.2	-2.4	1.5	1.0266	-0.2
100 OR MORE RESIDENTS	250	9.2	-9.4	-5.8	0.9331	-0.9	-6.4	-2.7	0.9643	-0.6
DISPROPORTIONATE SHARE PATIENT RATIO										
0	25	25.1	-0.3	3.6	0.9250	-0.1	-1.2	2.7	0.9175	-0.3
0.001- 0.099	916	10.3	-4.9	-1.1	0.9780	-0.5	-5.8	-2.1	0.9682	-0.6
0.100- 0.159	1,016	10.9	-0.9	3.0	1.0447	-0.1	-1.9	1.9	1.0337	-0.2
0.160- 0.299	1,613	10.1	-3.0	0.8	1.0113	-0.3	-3.7	0.0	1.0039	-0.4
GREATER THAN 0.299	1,294	9.2	-6.6	-2.9	0.9617	-0.6	-3.5	0.3	0.9934	-0.3

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Based on our analyses, we are not proposing to make adjustments to the outpatient payment rates for disproportionate share patient percentage and teaching intensity and rural location for the following reasons.

1. Estimated effects of teaching intensity and disproportionate share patient percentage on costs were small and, in some cases, not statistically significant.

2. Payment impacts without such adjustments do not vary considerably, the largest being a reduction of 5.8 percent for major teaching hospitals. These impacts should also be evaluated in terms of the overall effect on Medicare payments since on average, outpatient services account for 10 percent of hospitals' Medicare payments. For example, the associated reduction of total Medicare payments for major teaching hospitals would be about 1 percent.

3. With the threshold adjustments we considered, estimated payment reductions for rural hospitals would be 1.9 percent under the proposed system, rather than 1.5 percent. These hospitals also receive a greater percent of their Medicare income (14.7 percent) from providing outpatient services. Similarly, payment reductions for low-volume rural hospitals would be 13.9 percent of current payments, rather than 13.7 percent, and these hospitals also earn a greater percentage of their Medicare income (18.2 percent) from providing outpatient services. Because of these potential shifts in payments, any adjustment should be based on stronger analytic results than those found with the current data.

4. We also believe the issue of payment adjustments should be reexamined using data from initial years of the implemented system because current cost calculations and relationships among key factors and costs probably are affected by variation in coding patterns.

5. HCFA is working towards standardizing payment across all sites of service. Fewer adjustments to the outpatient PPS would allow HCFA to move ahead more quickly with this approach.

6. We believe that we should further analyze the impact of basing APC weight calculations on the median rather than the geometric mean because better correlation between costs and service mix would impact the size of adjustments.

Although the payment simulations show potentially large percentage losses and low payment to cost ratios for low-volume hospitals, we are not proposing an adjustment for volume. The low-volume hospitals get a much greater percent of their Medicare income from the provision of outpatient services than the average, and total Medicare payments would drop by 3.1 percent for rural low-volume hospitals and 1.8 percent for urban low-volume hospitals. Low-volume hospitals have higher than average standardized unit costs, which may be attributable to economies of scale, under-coding, or cost allocations to the outpatient departments that are not volume related. However, an adjustment to the rates based on volume alone might reward inefficiency and create adverse incentives such as a reduction in services in order to increase payment rates. Moreover, these hospitals do not comprise a large enough proportion of other hospital types to substantially benefit from other adjustments (for example, teaching or disproportionate share).

We are particularly concerned about the potential impact of the outpatient PPS on low-volume rural hospitals that are sole community hospitals or Medicare-dependent hospitals. Approximately 60 percent of the rural hospitals furnishing fewer than 5,000 visits fall into these categories. We are investigating the reasons for their higher costs and are assessing whether a temporary adjustment is needed to moderate the impact of moving to an outpatient PPS. One option we are considering would be to phase-in the outpatient PPS for low-volume Medicare-dependent and sole community hospitals by paying a portion of the payment based on PPS rates and a portion based on the current payment system. For example, payment could be based on 75 percent of payments under the current system and 25 percent on PPS rates in the first year, 50 percent current system payments and 50 percent PPS rates in the second year, 25 percent current system payments and 75 percent PPS rates in the third year, and completely on PPS rates in subsequent years. Another option we are considering would phase-in outpatient PPS if a low-volume sole community hospital or Medicare-dependent hospital has a negative Medicare margin for outpatient services. For example, payment could be based on the amount payable under outpatient PPS plus a percentage of the difference between those amounts and the amounts payable under the current system. The percentage of the difference that would be payable could phase down, for example, 75 percent in year one of implementation, 50 percent in year 2, 25 percent in year 3, and no adjustment in year 4 and subsequent years. We solicit comment on this and other alternatives we might consider. By statute, any adjustment would have to be budget neutral.

We also are not proposing adjustments for cancer or TEFRA hospitals at this time. We believe that claims from cancer and TEFRA hospitals have been under-coded for many of the services cancer hospitals provide due to the lack of payment incentives for proper coding of these services under the current system. Further analysis will be conducted to determine if current coding practices explain the negative impact. If we determine that cancer hospitals would be unduly harmed because of the new outpatient PPS, we will consider whether an adjustment or perhaps a transition period is needed to moderate the impact. By statute, any adjustment would have to be budget neutral.

We do not believe that this action will restrict beneficiary access because other hospitals provide many of the same services provided at TEFRA hospitals. In addition, children's and free-standing psychiatric hospitals are less dependent than other hospitals on Medicare revenues. Finally, the remaining classes of TEFRA hospitals, rehabilitation and long-term care, lose a much smaller percentage of their total Medicare income, 3.7 and 3.5 percent respectively than the average for all facilities.

We are not proposing adjustments for any eye and ear or trauma hospitals because payment simulations demonstrated an increase in payments under the proposed PPS. We will assess the need for additional adjustments and make any appropriate changes as data become available under the new system.

J. Volume Control Measures

Section 1833(t)(2)(F) of the Act requires us to develop a method for controlling unnecessary increases in the volume of covered outpatient department services, including partial hospitalization services in CMHCs. If the volume of services paid for increases beyond amounts established through methodologies determined in section 1833(t)(2)(F), section 1833(t)(6)(C) provides that the update to the conversion factor may be adjusted. MedPAC recommends in its report to the Congress that we implement an expenditure cap to help control spending for hospital outpatient services and that we monitor hospital outpatient volume to ensure that access to services and quality of care are not reduced under a cap.

In this proposed rule, we are proposing a volume control measure for services furnished in CY 2000. In the

proposed rule for rates that would be effective in CY 2001, we plan to propose an appropriate method for determining expenditure targets for services furnished in CY 2001 and subsequent years, following completion of further analysis of how that target should be computed. Later in this section, we discuss several possible approaches for controlling the volume of hospital outpatient services furnished in CY 2001 and subsequent years.

Pursuant to section 1833(t)(2)(F) and consistent with section 1833(t)(6)(C), we are proposing to update the target amount specified under section 1833(t)(3)(A) for CY 1999 as an expenditure target for services furnished in CY 2000. We will update the CY 1999 target for inflation (based on the projected change in the hospital market basket minus one percentage point) and estimated changes in the volume and intensity of hospital outpatient services and estimated Part B fee-for-service changes in enrollment. If volume exceeds the target for CY 2000, we are proposing to adjust the update to the conversion factor for CY 2002. We will compare the CY 2000 target to an estimate of CY 2000 actual payments to hospitals. (HCFA's Office of the Actuary will determine the CY 2000 actual payments using the best available data.) If unnecessary volume increases, as reflected by expenditure levels, cause payments to exceed the target, we will determine the percentage by which the target is exceeded, and adjust the CY 2002 update to the conversion factor by the same percentage.

In conjunction with the Office of Inspector General, we are proposing to do further work to assure that only payments made in accordance with existing Medicare law and regulations were used in the calculation of the target amount. If this work reveals that adjustments to the target amount and expenditure ceiling are warranted, we will address this issue in a future rule.

When the inpatient PPS was implemented, the packaging of all services provided during an admission under a single rate was the primary method of volume control. This method was appropriate because the concern was the intensity of services per admission, rather than the number of admissions, which was generally stable. For outpatient department services, there has been rapid growth in the intensity of ancillary services per procedure. We believe that greater packaging of these services might provide volume control. However, because the hospital outpatient PPS will not initially include a significant degree of packaging, we are examining a number of mechanisms to control unnecessary increases, as reflected by expenditure levels, in the volume of covered outpatient department services. The volume of services is a significant concern, particularly during the first few years of the outpatient PPS, because of the possible incentives under PPS to increase utilization.

Although the updated target amount provides a basis against which we can measure year 2000 actual payments, we need to develop an approach for establishing a volume control measure for years 2001 and beyond. Because of the complexities involved in developing such a system, we do not plan to propose a method for future years (2001 and beyond) until we issue our notice of proposed rulemaking for CY 2001, but we want to open a discussion now, so that we can obtain comments that we can use in developing a proposal.

One possible mechanism to control unnecessary increases in the volume of outpatient services paid for under the outpatient PPS is to expand the sustainable growth rate (SGR) system for physician services, which is required under section 1848(d)(3) of the Act, as amended by section 4502 of the BBA, to take into account hospital outpatient services. Physicians typically are responsible for ordering medical services and are thus responsible for determining a substantial portion of hospital outpatient volume. Expanding the SGR system for physician services to include hospital outpatient services would provide added incentives for physicians to evaluate the necessity of orders for hospital outpatient services.

A second possible mechanism would be to expand the SGR system for physician services to include all ambulatory services, for example, services in hospital outpatient departments and ASCs, and to use this expanded SGR system to establish updates for the ambulatory facility payments as well as for physician fee schedule updates. This method would spread volume control incentives more evenly across the ambulatory sector. It would more closely align physician and facility incentives and be less sensitive than a hospital-outpatient-department-only SGR to shifts in site of service.

A third approach to controlling unnecessary growth in the volume of hospital outpatient services is to modify the physician SGR method and incorporate it into the hospital outpatient department payment system. That is, as in the physician payment context, an SGR value for hospital outpatient services would be calculated and payment updates for these services would be reduced if volume increases result in expenditures above target levels.

We believe the third option of linking updates of the outpatient department conversion factor to an SGR system is the most feasible approach to take initially. Additional study, analysis, and possible legislative modification would be necessary before we could consider implementing either of the first two options discussed above. We acknowledge that, to the extent that hospital outpatient volume is physician driven, an outpatient SGR could arguably be viewed as unnecessarily and unfairly penalizing facilities. Moreover, because sites of ambulatory care are relatively interchangeable with respect to the delivery of outpatient services, setting appropriate targets for hospital outpatient departments alone could be difficult. However, an outpatient SGR system would parallel the SGR system created for physician services under section 4502 of the BBA. Physician volume issues have been extensively analyzed by MedPAC, and the SGR system for physicians has evolved as a feasible method for volume control. Many outpatient PPS issues are similar to physician issues because changes in technology and places of service can affect expenditures for both hospital outpatient departments and physicians.

The outpatient SGR system would base volume and intensity growth allowances for services under the outpatient PPS on the growth in the general economy. Other factors in determining the target rate of growth include medical inflation, changes in enrollment, and changes in spending due to changes in the law or regulations. The outpatient SGR would be calculated as the product of—

(1) The annual update to the conversion factor (described in section V.G.3. of this preamble), which is the outpatient market basket percentage increase reduced by one percentage point for the years 2000, 2001, and 2002.

(2) The percentage increase or decrease in Part B enrollees (excluding those enrolled in Medicare+Choice) from one year to the next;

(3) The projected growth in the real gross domestic product per capita (or real gross domestic product per capita plus an appropriate factor for recent outpatient department services growth) from the previous year to the year involved; and

(4) The percentage change in spending for outpatient department services resulting from changes in law and regulations from one year to the next.

This growth rate system would be used in setting annual updates to the conversion factor for hospital outpatient services. Pursuant to section 1833(t)(2)(F) of the Act, and consistent with section 1833(t)(6)(C), we would lower the annual update to the conversion factor for a given year if volume increases cause expenditures to exceed the target amount in a previous year. While we think using an outpatient department SGR is the most feasible option in the short term, in the long term we would like to develop a more integrated approach that addresses physicians and ASCs, as well as outpatient departments. In addition to requesting comments on our proposed volume control measure for services furnished in CY 2000, we specifically solicit comments on the appropriateness of applying the SGR method directly to payments made under the outpatient PPS for future years. We also welcome comments on the development of a long-term integrated system that we would consider as we develop possible future proposals. In our final rule, we will respond to comments on our proposed volume control measure for services furnished in CY 2000. We do not intend to respond to comments concerning the development of an SGR system for services furnished after CY 2000, an integrated system, or any other approach. However, we will use any comments we receive in developing a proposal we will make next year for volume control measures to be applied to services furnished after CY 2000.

K. Prohibition Against Administrative or Judicial Review

Section 1833(t)(9) of the Act prohibits administrative or judicial review of the PPS classification system, the groups, relative payment weights, adjustment factors, other adjustments, volume control methods, calculation of base amounts, periodic control methods, periodic adjustments, and the establishment of a separate conversion factor for cancer hospitals.

VI. Hospital Outpatient Clinics and Other Provider-Based Entities

A. Background

The Medicare law (section 1861(u) of the Act) lists the types of facilities that are regarded as providers of services, but does not use or define the term ''provider-based.'' However, from the beginning of the Medicare program, some providers, which are referred to in this section as ''main providers,'' have owned and operated other facilities, such as SNFs or HHAs, that were administered financially and clinically by the main provider. The subordinate facilities may have been located on the main provider campus or may have been located away from the main provider. In order to accommodate the financial integration of the two facilities without creating an administrative burden, we have permitted the subordinate facility to be considered provider-based. The determination of provider-based status allowed the main provider to achieve certain economies of scale. To the extent that overhead costs of the main provider, such as administrative, general, housekeeping, etc. were shared by the subsidiary facility, these costs were allowed to flow to the subordinate facility through the cost allocation process in the cost report. This was considered appropriate because these facilities were also operationally integrated, and the provider-based facility was sharing the overhead costs and revenue producing services controlled by the main provider.

Before implementation of the hospital inpatient PPS in 1983, there was little incentive for providers to affiliate with one another merely to increase Medicare revenues or to misrepresent themselves as being provider-based, since at that time each provider was paid primarily on a retrospective, cost-based system. At that time, it was in the best interest of both the Medicare program and the providers to allow the subordinate facilities to claim provider-based status, because the main providers achieved certain economies, primarily on overhead costs, due to the low incremental nature of the additional costs incurred. For example, the billing department of a main provider could usually accommodate the additional workload associated with a provider-based facility by hiring an additional billing clerk, instead of incurring the cost of a separate billing department for the provider-based facility. This economy of scale would usually extend to the other overhead costs incurred by the main provider, because the free-standing facility was generally more costly to maintain than one that was provider-based. This was due primarily to the savings on overhead costs that were accomplished by the merging of the free-standing facility into the main provider and having it integrated with the main provider. Although there were several limited guidelines outlining the conditions for certain provider-based situations, we devoted few resources to reviewing provider compliance, because there was little incentive for providers to use this designation inappropriately.

Since 1983, the number of provider-based facilities has increased significantly. For example, in July of 1982, there were 481 provider-based HHAs as compared with 2,577 provider-based HHAs in October of 1996. This was an increase of 435.75 percent in the 13 years since the PPS was established. In addition, many hospitals now have a large number of outpatient clinics, often located at various sites.

We believe the growth in the number of facilities and organizations claiming to be provider-based has occurred for several reasons. First, the PPS established payment rates using base year costs that included provider overhead. Health care providers, looking for ways to increase their Medicare revenues, realized that if they established provider-based facilities or organizations that were still subject to the reasonable cost principles, they would then be able to shift some of the overhead from the hospital inpatient operating costs to these provider-based facilities or organizations. The PPS main provider would be paid a PPS payment that was intended to cover overhead costs, as well as being reimbursed on a reasonable cost basis based on Medicare's share of the overhead costs for the services furnished by the provider-based facility or organization. A main provider that is excluded from PPS and subject to the rate-of-increase limits would also benefit from shifting its overhead to the subordinate provider-based facility or organization. This cost shifting would enable it to increase its payment by being paid for the Medicare share of the diverted overhead on a cost-based methodology, as well as bringing its costs below the rate-of-increase limit. The main provider could then share in the incentive payment by having its costs come in below the target rate.

More recently, other factors have combined to create incentives for providers to affiliate with one another and to acquire control of nonprovider treatment settings, such as physician offices. Integrated delivery systems offer a wide variety of health care services and can assume responsibility for entire episodes of a patient's illness. These systems are attractive to patients, who seek continuity of care, and to businesses seeking a single source of health services for their employees. The resulting growth in the number of patients enrolled by these integrated delivery systems has created a powerful incentive for affiliations. In addition, hospitals rely on referrals from physicians to assure a steady stream of patients, and they have begun to purchase physician practices and integrate them into their outpatient operations. This trend also has created

incentives for hospitals to affiliate with physician practices.

B. Effects on Medicare

For several reasons, it is essential that we ensure that decisions regarding provider-based status are made appropriately, and that facilities or organizations are not recognized as provider-based unless they are in fact integral and subordinate parts of the main provider. As noted earlier, in cases where main providers are paid under the PPS and subordinate facilities or organizations are paid under the reasonable cost reimbursement method (section 1861(v)(1)(A) of the Act and 42 CFR part 413), a provider-based determination could allow the main provider to shift overhead costs to cost centers that are paid on a cost basis and thereby increase Medicare payments with no commensurate benefit to the Medicare program or its beneficiaries.

Payments for services furnished in a hospital outpatient clinic generally include both a facility payment and payment for the professional services of a physician. The combined payments are typically higher than the payment for comparable services furnished in a physician office, where a separate facility fee is not payable. In many cases, there is also an increase in beneficiaries' out-of-pocket expenses compared to services furnished in a physician office. For example, when a beneficiary is treated in a physician office, the only payment made is Part B payment to the physician for his or her professional services, under the physician fee schedule. The single payment made under the physician fee schedule pays for the physician's work and includes a component for practice expense. The beneficiary's coinsurance is based on 20 percent of the physician fee schedule amount. However, if the same service is furnished in a hospital outpatient clinic, Medicare Part B payment for a facility fee is also made to the hospital, in addition to the physician's payment (which may include a smaller practice expense component). Thus, for the same visit, the beneficiary is also subject to the Part B coinsurance for the hospital's facility fee. Beneficiaries are responsible for coinsurance based on 20 percent of the hospital's charges (or, the applicable coinsurance amounts under the hospital outpatient PPS).

Provider-based status also raises issues of Medicare coverage. Generally, the services of nonphysician staff furnished in a physician office are covered only as services ''incident to'' the professional services of a physician under section 1861(s)(2)(A) of the Act. This means that a physician must be available on the premises when the service is furnished, in order to provide direct supervision of that service. In hospital outpatient departments, however, we presume that the ''incident to'' requirements are met with respect to hospital services incident to physician services to outpatients (section 1861(s)(2)(B)). The policy assumed the outpatient department was co-located on the hospital premises and staff physicians would be available nearby to provide necessary oversight. It is possible that a hospital outpatient clinic may not be in the immediate vicinity of the hospital and may furnish nonphysician services without actually providing for direct physician supervision of those services. We do not believe that such services should be presumed to meet applicable ''incident to'' requirements. As explained below, it could also present a health and safety risk at a time when the office is staffed with nonphysician personnel who are furnishing medical care with no physician present and available to attend to any unexpected emergency situation that may arise.

Provider-based status for a facility or organization can have other implications for the health and safety of its patients. Hospital outpatient facilities are subject to the Medicare conditions of participation in 42 CFR part 482, including specific requirements covering such crucial areas as adequacy of physician care (§ 482.22, ''Conditions of participation: Medical staff''), and the safety of the physical environment, including compliance with fire safety requirements (§ 482.41, ''Conditions of participation: Physical environment''). Beneficiaries have the right to expect that any outpatient department of a hospital meets applicable conditions of participation and that the facility is capable of providing care commensurate with the general level of care furnished in a hospital outpatient department that is co-located with the inpatient setting. However, the facility claimed as an outpatient department may not have been surveyed for compliance with the conditions of participation and, in some cases, we may not even have been notified of its existence.

The BBA includes several new provisions that can be implemented appropriately only if clear distinctions are made between free-standing and provider-based facilities. Section 4205(a)(1) of the BBA amended section 1833(f) of the Act to extend the per-visit payment limit for rural health clinics (RHCs), which previously applied only to free-standing RHCs, to most provider-based RHCs as well. (The law provides that the limit does not apply to RHCs located in hospitals with less than 50 beds.)

Section 4541 of the BBA amended section 1833 of the Act to establish a prospective system of payment for outpatient physical therapy services (including outpatient speech-language pathology services) and outpatient occupational therapy services furnished after 1998, and to establish a $1,500 annual limit on the amount of payment for such services to each beneficiary. Under sections 1833(g)(1) and (g)(2) of the Act, however, that limit does not apply to services furnished in hospital outpatient departments. Moreover, as explained later in this section of the preamble, there are differences in payment for ambulatory surgical services, depending on whether the services are furnished in a hospital, by an approved ASC, or in a physician office. Further, higher composite rate payments are made to hospital-based ESRD facilities than to free-standing ESRD facilities. Thus, it is essential that we have clear rules for identifying provider-based facilities.

C. Relationship of the ''Provider-Based'' Proposals to Prospective Payment for Outpatient Hospital Services and Effective Date of ''Provider-Based'' Proposals

Although the proposed regulations set forth in new § 413.65 and in the amendment to § 413.24 relate to providers generally, their implementation is crucial to successful implementation of a PPS for outpatient hospital services. No outpatient PPS can succeed if it does not clearly define the services to which it applies. Experience suggests that under the existing policies defining provider-based status, many ambulatory services may be characterized either as physician office services or as services of hospital outpatient departments or clinics or an ASC, depending on the financial incentives involved. Thus, we are publishing these proposed rules to permit clearer distinctions to be made between various types of services, and to ensure that services paid for under the outpatient PPS are of the same type as those included in the data on which the system is based.

As explained in the previous section of this preamble, it is essential that provider-based decisions be made appropriately in all cases, not just those involving outpatient hospital services paid for under a PPS. Therefore, the effective date of these proposals will not be delayed until after an outpatient PPS is in effect. On the contrary, we plan to

implement proposed §§ 413.24(d)(6)(i) and (ii), 413.65, 489.24(b), and 498.3, as revised based on our consideration of public comments, with respect to services furnished on or after 30 days following publication of a final rule.

D. Basis for Current Provider-Based Policy

Although there is no direct statutory requirement to maintain explicit criteria for determination as to provider-based status, there are statutory references acknowledging the existence of this payment outcome. For example, section 1881(b) of the Act provides for separate payment rates for hospital-based (ESRD) facilities.

There is currently no general definition of ''provider-based facility'' in the CFR. However, various sections of the CFR do contain provisions for recognition of specific types of entities as provider-based.

Section 405.2462(a) authorizes payment for RHCs and Federally qualified health centers (FQHCs) as provider-based, if:

(1) The clinic or center is an integral and subordinate part of a hospital, SNF, or HHA participating in Medicare, (that is, a provider of services); and

(2) The clinic or center is operated with other departments of the provider under common licensure, governance, and professional supervision.

Definitions of hospital-based HHAs and SNFs were published in final notices on cost limits for HHAs and SNFs, in the June 5, 1980 (45 FR 38014) and September 4, 1980 (45 FR 58699) issues of the **Federal Register**, respectively. These criteria were identical to one another and were similar to the RHC and FQHC definition but they provided considerably more detail in their description of common governance.

Further, we have provided additional detail regarding the factors to be considered in making determinations regarding provider-based status in our manuals. The Medicare Regional Office Manual at section 6860 provides a list of criteria that should be considered in making a determination regarding provider-based status for clinics. Also, section 2186 of the State Operations Manual provides direction regarding provider-based designation for HHAs.

Program Memorandum A–96–7, published on August 27, 1996, pulled together the instructions previously manualized for specific entity types into a general instruction for the designation of provider-based status to all facilities or organizations. In developing this Program Memorandum, we took information from the State Operations Manual (sections 2024, 2186, and 2242), the Regional Office Manual (section 1060, 2020 and 6865), and §§ 405.2462 and 413.170 of the CFR.

Under the policy we set forth in Program Memorandum A–96–7, the following applicable requirements must be met before an entity can be designated as provider-based for Medicare payment purposes:

1. The entity is physically located in close proximity of the provider where it is based, and both facilities serve the same patient population (for example, from the same service, or catchment area);

2. The entity is an integral and subordinate part of the provider where it is based, and as such, is operated with other departments of that provider under common licensure (except in situations where the State separately licenses the provider-based entity);

3. The entity is included under the accreditation of the provider where it is based (if the provider is accredited by a national accrediting body) and the accrediting body recognizes the entity as part of the provider;

4. The entity is operated under common ownership and control (that is, common governance) by the provider where it is based, as evidenced by the following:

- The entity is subject to common bylaws and operating decisions of the governing body of the provider where it is based;
- The provider has final responsibility for administrative decisions, final approval for personnel actions, and final approval for medical staff appointments in the provider-based entity; and
- The entity functions as a department of the provider where it is based with significant common resource usage of buildings, equipment, and service personnel on a daily basis.

5. The entity director is under the direct day-to-day supervision of the provider where it is located, as evidenced by the following:

- The entity director or individual responsible for day-to-day operations at the entity maintains a daily reporting relationship and is accountable to the Chief Executive Officer of the provider and reports through that individual to the governing body of the provider where the entity is based; and
- Administrative functions of the entity, for example, records, billing, laundry, housekeeping and purchasing are integrated with those of the provider where the entity is based.

6. Clinical services of the entity and the provider where it is located are integrated as evidenced by the following:

- Professional staff of the provider-based entity have clinical privileges in the provider where it is based;
- The medical director of the entity (if the entity has a medical director) maintains a day-to-day reporting relationship to the chief medical officer or other similar official of the provider where it is based;
- All medical staff committees or the professional committees at the provider where the entity is based are responsible for all medical activities in the provider-based entity;
- Medical records for patients treated in the provider-based entity are integrated into the unified records system of the provider where the entity is based;
- Patients treated at the provider-based entity are considered patients of the provider and have full access to all provider services; and
- Patient services provided in the entity are integrated into corresponding inpatient and/or outpatient services, as appropriate, by the provider where it is based.

7. The entity is held out to the public as part of the provider where it is based (for example, patients know they are entering the provider and will be billed accordingly).

8. The entity and the provider where it is based are financially integrated as evidenced by the following:

- The entity and the provider where it is based have an agreement for the sharing of income and expenses, and
- The entity reports its cost in the cost report of the provider where it is based using the same accounting system and the same cost reporting period as the provider where it is based.

Our policy will continue to follow the principles we articulated in Program Memorandum A–96–7 until 30 days after this rule is published as final in the **Federal Register**. After that date, we will apply the policies set forth in the final regulations.

E. Provisions of This Proposed Rule

This proposed rule would add a new § 413.65, stating the appropriate definitions of, and the general requirements for, the determination of ''provider-based'' status. In paragraph (a), we are proposing to define the following terms for purposes of this section: department of a provider, free-standing facility, main provider, provider-based entity, and provider-based status. The definitions used are as follows.

Department of a provider means a facility or organization or clinic that is

either created by, or acquired by, a main provider for the purpose of furnishing health care services under the name, ownership, and financial and administrative control of the main provider in accordance with the provisions of proposed § 413.65. A department of a provider is not licensed or certified to provide services in its own right, and Medicare conditions of participation do not apply to the department as an independent entity. The term ''department of a provider'' does not include an RHC or FQHC; however, an RHC or FQHC could qualify as a provider-based entity.

Free-standing facility means an entity that furnishes health care services to Medicare beneficiaries, and that is not integrated with any other entity as a main provider, a department of a provider, or a provider-based entity.

Main provider means a provider that either creates or acquires ownership of another entity to deliver additional health care services under its name, ownership, and financial and administrative control.

Provider-based entity means a provider, or an RHC or FQHC as defined in § 405.2401(b), that is either created by, or acquired by, a main provider for the purpose of furnishing health care services under the name, ownership, and administrative and financial control of the main provider in accordance with the provisions of proposed § 413.65. A provider-based entity is certified to provide services in its own right.

Provider-based status means the relationship between a main provider and a provider-based entity, or a department of a provider, that is in compliance with the provisions of proposed § 413.65.

We are proposing to state explicitly, in new paragraph (b), that a facility or organization is not entitled to be treated as provider-based simply because it or the provider believe it to be provider-based. We also would state that, if a facility or organization seeking provider-based status is located off the campus of a provider, or inclusion of the costs of the facility or organization on the provider's cost report would increase the total costs on that report by at least 5 percent, HCFA will not treat the facility or organization as provider-based for purposes of billing or cost reporting unless the provider has contacted HCFA and obtained a determination of provider-based status. This means that we would not accept billings from the facility or organization as if it were provider-based, and the provider will not be permitted to include costs of the facility or organization on its cost report, unless the acquisition or creation of the facility or organization has been reported to us and we have determined that it is either a department of a provider or a provider-based entity. Further, a facility not located on the campus of a hospital and used as a site of physician services of the kind ordinarily furnished in physician offices will be presumed to be a free-standing facility unless it is determined by HCFA to have provider-based status. For example, a physician office practice purchased by a main provider would not qualify for provider-based status unless it meets all applicable criteria in proposed § 413.65.

We are proposing to require, in new paragraph (c), that a main provider that acquires a facility or organization for which it wishes to claim provider-based status must report its acquisition of the facility or organization to HCFA and furnish all information needed for a determination as to whether the facility or organization meets the criteria in this section for provider-based status. A main provider that has had one or more facilities or organizations determined to have provider-based status also must report to HCFA any material change in the relationship between it and any department or provider-based entity, such as a change in ownership of the entity or entry into a new or different management contract, that could affect the provider-based status of the department or entity.

In new paragraph (d), we propose the requirements for a determination of ''provider-based status.'' In paragraph (d)(1), we would set forth licensure requirements for facilities or organizations seeking provider-based status. Any facility or organization seeking to be a department of a provider would have to be operated under the same license as the main provider. We note that if a State's licensure laws establish restrictions on the type or location of facilities or organizations that can be licensed as part of a provider, we would defer to those restrictions in determining whether a particular facility is a department of the provider. For example, if the hospital licensure laws of a particular State precluded facilities located more than 5 miles from a hospital from being licensed as part of the hospital, we also would not consider those facilities to be a part of the hospital. Provider-based entities would not have to be operated under the same license as the main provider, since in most cases we expect that they would be separately licensed by the State. To take account of possible State-by-State differences in licensure, however, we would require only that a prospective provider-based entity be licensed in accordance with the law of the State in which it is located.

In addition, if a State health facilities' cost review commission, or other agency that has authority to regulate the rates charged by hospitals or other providers in a State, finds that a particular facility or organization is not part of a provider, we also would determine that the facility or organization does not have provider-based status. We believe it would be inappropriate for a facility or organization to be considered free-standing for State ratesetting purposes, but provider-based status under Medicare.

In paragraph (d)(2), we would require that a facility or organization be under the ownership and control of the main provider. In particular, we would require that the facility or organization be 100 percent owned by the provider, that the main provider and a facility or organization seeking provider-based status have the same governing body, and that the facility or organization be operated under the same organizational documents as the main provider. For example, the facility seeking provider-based status would have to be subject to the bylaws and operating decisions of the governing body of the main provider. In addition, we would require that the main provider have final responsibility for administrative decisions, final approval for outside contracts, final responsibility for personnel policies, and final approval for medical staff appointments in the department or entity.

In paragraph (d)(3), with respect to administration and direct supervision of the main provider, we are proposing to require that a facility or organization seeking provider-based status have a reporting relationship to the main provider that is characterized by the same frequency, intensity, and level of accountability that exists in the relationship between the main provider and one of its departments. As evidence of this relationship, we would look to whether the facility is under the direct supervision of the provider where it is located, whether it is operated under the same monitoring and oversight as any other department of the provider, and is operated as any other department with respect to supervision and accountability. We would expect the director or individual responsible for daily operations at the facility or organization to maintain a day-to-day reporting relationship with a manager at the main provider and to be accountable to the main provider's governing body in the same manner as any department head of the provider. We also would require integration of certain

administrative functions, in particular, billing services, records, human resources, payroll, employee benefit package, salary structure, and purchasing services. Either the same employee or group of employees would have to handle these administrative functions for both the facility or organization and the main provider, or the administrative functions for the entity and the main provider would have to be contracted out under the same contractual agreement, or be handled under different contract agreements, with the entity's contract being managed by the main provider's billing department.

In paragraph (d)(4), we are proposing that a facility or organization seeking provider-based status and the main provider share integrated clinical services, as evidenced by privileging of the professional staff of the department or entity at the main provider, and the main provider's maintenance of the same monitoring and oversight of the department or entity as of other departments. Also, the medical director of the department or entity must maintain a day-to-day reporting relationship with the chief medical officer (or equivalent) of the main provider, and be under the same supervision as any other director of the main provider. We also would expect medical staff committees or other professional committees of the main provider to be responsible for medical activities in the department or entity, including quality assurance, utilization review, and the coordination and integration of services. We also would expect medical records to be integrated into a unified retrieval system. We would expect that inpatient and outpatient services of the facility or organization and the main provider be integrated and that patients treated at the facility or organization who require further care have full access to all services of the main provider, including all inpatient or outpatient services of the main provider.

In paragraph (d)(5), we would require that the proposed department or entity and the main provider be fully financially integrated within the main provider's financial system, as evidenced by the sharing of income and expenses. The department's or entity's costs should be reported in a cost center of the provider, and the department's or entity's financial status should be incorporated into, and readily identifiable in, the main provider's trial balance.

In paragraph (d)(6), we would require that the main provider and the facility seeking status as a department of the provider be held out to the public as a single entity, so that when patients enter the department they are aware that they are entering the provider and will be billed accordingly. (This requirement would not apply to a provider-based entity that is itself a provider, such as a SNF.)

In paragraph (d)(7), we would require that the department of a provider or provider-based entity and the main provider be located on the same campus. Alternatively, the main provider and facility seeking provider-based status must demonstrate that they serve the same patient population. The department or entity and the main provider would be required to demonstrate that they serve the same patient population by submitting patient lists and/or demographic data showing that a high percentage of the patients of both come from the same geographic area, or that patients of the entity also receive a preponderance of services from the main provider. We would specify that a facility or organization is not considered to be in the ''immediate vicinity'' of the main provider if it is located in a different State than the main provider. We welcome comments as to whether an exception should be made for areas where a single metropolitan area may include two or more States.

New paragraph (e) would specifically prohibit the approval of provider-based status for any proposed department or entity that is owned by two or more providers engaged in a joint venture. Some hospitals, under joint venture arrangements, are jointly purchasing or jointly creating free-standing facilities. Although the facility or organization is operated by two or more hospitals, the dominant hospital claims the free-standing facility or organization as a department or provider-based entity. This is clearly unallowable, because the facility or organization is owned by more than one hospital, and in its own right must be considered as free-standing, subject to all of the rules and certifications that govern that type of operation.

In proposed paragraph (f), we would state that facilities or organizations operated under management contracts will be considered provider-based only if specific requirements for staff employment, administrative functions, day-to-day control of operations, and holding of the management contract by the provider itself rather than by a parent organization are met. Generally, we believe it would be difficult for any facility or organization operated under a management contract to provide all services to be able to demonstrate the degree of integration with a provider that would be needed to qualify for provider-based status. Thus, we are proposing to adopt these requirements, which are designed to ensure that we treat a facility or organization under a management contract as provider-based only if it clearly is operated by the provider, not by the management company or by a common parent organization.

In proposed paragraph (g), we would specify nine obligations of hospital outpatient departments and hospital-based entities. These obligations are spelled out in detail to help us ensure that facilities seeking recognition as hospital outpatient departments or hospital-based entities are in fact what they represent themselves as being, and are not simply the private offices of individual physicians or of physicians in group practices. The obligations are—

—In the case of hospital outpatient departments located off the main provider campus, compliance with the anti-dumping requirements in §§ 489.20 (l), (m), (q), and (r) and 489.24. If any individual comes to any hospital-based entity (including an RHC) located on the main hospital campus and a request is made on the individual's behalf for examination or treatment of a medical condition, as described in § 489.24, the hospital must comply with the anti-dumping requirements in § 489.24. We would also revise § 489.24(b) to clarify that for purposes of the anti-dumping rules set forth in that section, hospital property means the entire main hospital campus, including the parking lot, sidewalk, and driveway, as well as any facility or organization that is located off the main hospital campus but has been determined under § 413.65 to be a department of the hospital.

—Billing of physician services in hospital outpatient departments or hospital-based entities (other than RHCs) with the correct site-of-service indicator, so that applicable site-of-service reductions to physician and practitioner payment amounts can be applied;

—In the case of hospital outpatient departments, compliance with all the terms of the provider agreement;

—Compliance by physician staff with the nondiscrimination provisions in § 489.10(b) of this chapter;

—In the case of hospital outpatient departments (other than RHCs), representation to other payers as an outpatient department of the hospital, and treatment of all patients, for billing purposes, as hospital outpatients;

—In the case of hospital outpatient departments or hospital-based entities, compliance with the payment window provisions applicable under § 412.2(c)(5) (for PPS hospitals) or § 413.40(c)(2) (for PPS-excluded hospitals);
—In the case of hospital outpatient departments or hospital-based entities (other than RHCs), notice to each beneficiary treated that he or she will be liable for coinsurance for a facility visit as well as for the physician service; and
—In the case of hospital outpatient departments, compliance with applicable Medicare hospital conditions of participation for hospitals in part 482 of this chapter.

We would also preclude any facility or organization that furnishes all services under arrangements from qualifying as provider-based. We believe the provision of services under arrangement was intended to be allowed only to a limited extent, in situations where cost-effectiveness or clinical considerations, or both, necessitate the provision of services by someone other than the provider's own staff. The ''under arrangement'' provision in section 1861(w)(1) of the Act and § 409.3 is not intended to allow a facility merely to act as a billing agent for another. We are concerned that this would be the case if all services at a facility or organization seeking provider-based status were furnished under arrangement. We believe use of arranged-for services could, if not limited, become a means of circumventing the provider-based requirements. We are proposing in paragraph (g)(10) that a facility or organization may not qualify for provider-based status if all of the services furnished at the facility are furnished under arrangements. We note that this approach is consistent with existing policy under which a hospital outpatient is expected to receive services, rather than supplies, directly from the hospital.

Proposed paragraph (h) states that if we learn of a provider that has inappropriately treated a facility or organization as provider-based, before obtaining our determination of provider-based status, we would reconsider all payments to that main provider for periods subject to reopening, investigate, and determine whether the designation was appropriate. If we find it was not provider-based, we will recover all payments in excess of those payments that should have been made in the absence of the provider-based status. As explained further below, however, recovery will not be made for any period prior to the effective date of this rule if during all of that period the management of the facility or organization made a good-faith effort to operate it as a department of a provider or provider-based entity.

In proposed paragraph (i), we would detail the application of the principles in paragraph (h) to situations involving inappropriate billing for services furnished in a physician office or other facility or organization as if they had been furnished in a hospital outpatient or other department of a provider or in a provider-based entity. Generally, when such cases of inappropriate billing are found, we will recover any overpayments as described in the preceding paragraph. Under certain circumstances, however, we will determine that the management of a facility or organization has made a good faith effort to operate it as a department of a provider or a provider-based entity and will not recover past payments. We would take this action if we determine that the requirements regarding licensure and public awareness in paragraphs (d)(1) and (d)(6) are met, all facility services were billed as if they had been furnished by a department of the main provider or a provider-based entity of the main provider, and all professional services of physicians and other practitioners were billed with the correct site-of-service indicator, as described in paragraph (g)(4).

We are also proposing to add a new paragraph (j) that would allow HCFA to review past determinations. If we find that a designation was in error, and the facility or organization in question does not meet the requirements of this section, we will notify the main provider that the provider-based status will cease as of the first day of the next cost report period following notification of the redetermination.

In addition, we are proposing to add to § 413.24(d) new paragraphs (6)(i) and (6)(ii) to clarify that main providers, in completing their Medicare cost reports, may not allocate overhead costs to the provider-based or other cost centers that incur similar costs directly through management contracts or other arrangements. These changes are needed to prevent mis-allocation of management costs, which would result in excessive payment to those types of providers paid on a reasonable cost basis.

As the number of affiliation agreements among various entities has increased, there has been a noticeable shift in the way the HHAs and clinics have been managed, resulting in increased Medicare payments. Today, there are many management companies that enter into contracts with main providers to manage their provider-based entities, and the costs of these management services are being directly assigned to the department or provider-based entity receiving the service. The contracts typically call for the management company to provide the billing and accounting services, and to procure services, such as housekeeping, laundry and linen, to enable the department or provider-based entity to operate away from the campus and supervision of the main provider, even though these management companies must report to the board of the main provider. In addition to directly assigning these costs to the department or provider-based entity, the main provider, through the cost report, is still allocating overhead costs to the department or provider-based entity, even though these services are being performed through the management contract and not through the main provider. Under these circumstances, the provider could be paid three times for the same overhead cost. The first payment would be made through the PPS payment, which reflects overhead cost. The second payment would come through the cost of the management contract, and the third would come through the allocation of a share of the main provider's overhead cost to the department or provider-based entity. Our proposed changes to § 413.24 are needed to prevent this result.

To provide an administrative appeals process for entities that have been denied provider-based status, we are proposing to revise the regulations on provider appeals at § 498.3. As revised, these rules would specify that a provider seeking a determination that a facility or an organization is a department of the provider or a provider-based entity under proposed § 413.65 will be included in the definition of ''prospective provider'' for purposes of part 498, and will be afforded the same appeal rights as a prospective provider, such as a hospital or SNF, that has been found by HCFA not to qualify for participation as a provider. We believe it is in the best interest of both HCFA and health care organizations to have an explicit procedure for handling these appeals.

F. Requirements for Payment

The following discussion sets out the requirements that must be met to allow us to make payment under the outpatient PPS for various services.

1. Prerequisites for Payment for Outpatient Hospital Services and Supplies Incident to Physician Services

Medicare Part B benefits include payment for services and supplies that are furnished incident to the professional services of a physician. Medicare makes payment for services and supplies furnished in physician offices that are incident to a professional service of a physician under the provisions of the Medicare physician fee schedule (section 1848 and section 1861(s)(2)(A) of the Act; 42 CFR part 414). Payment for the ''incident to'' services furnished in physician offices is generally included within the fee for the physician services. Medicare also makes payment for hospital services and supplies that are incident to a physician service furnished to outpatients (section 1861(s)(2)(B) of the Act). Payment for ''incident to'' services furnished to hospital outpatients is *in addition to* payment for the professional services of a physician. The place where ''incident to'' services are furnished determines how Medicare pays for them.

We are proposing to add to the regulations certain prerequisites that the hospital must fulfill before it can receive Medicare payment under section 1861(s)(2)(B) of the Act for services and supplies furnished ''incident to'' physician services at a site that is off the premises of the main hospital complex. These prerequisites are intended to adapt our current policy regarding payment for ''incident to'' services furnished to hospital outpatients to address the special circumstances presented by a hospital outpatient department or clinic that is not co-located on the hospital campus or within a short distance of the hospital and that HCFA has designated is a department of the hospital or ''provider-based.''

The first prerequisite is that the office/clinic meet the responsibilities and criteria incumbent upon a provider-based entity as defined in § 413.65(g). We are proposing this requirement because the fact that a hospital owns and/or operates a clinic does not automatically make that clinic an integral, subordinate part of the hospital. If the clinic does not conform with the responsibilities and criteria at § 413.65(g), that clinic would be paid as a physician office, and Medicare payment for services furnished at that site would be made accordingly.

The second prerequisite is that the hospital seek an official determination from HCFA that the provider-based designation applies to the proposed off-site hospital outpatient department/clinic as required by § 413.65(d). The authority to determine whether or not an entity has provider-based status rests solely with HCFA. The criteria and obligations that are a prerequisite of a provider-based hospital outpatient designation are discussed earlier in this section.

Current regulations require that, in order to be paid for as ''incident to'' services, outpatient hospital services and supplies are to be furnished as an integral though incidental part of a physician service (§ 410.27(a)(1)(ii)). In addition, as a matter of policy, we require that the services and supplies be furnished on a physician's order by hospital personnel and under a physician's supervision (Intermediary Manual, section 3112.4(A)). When ''incident to'' services are furnished on hospital premises, we assume the physician supervision requirement to be met because staff physicians would be present nearby within the hospital. We also allow staff in a department of the hospital other than that of the ordering physician to supervise the services. We equate the location of the hospital outpatient department or hospital clinic within the hospital's walls, or their co-location on the same campus, with being ''on the hospital premises,'' and we assume physician supervision is always at hand. In the interests of beneficiary health and safety, we do not believe it is reasonable, safe, or appropriate to extend these assumptions to a hospital outpatient department or hospital clinic that is located off-site and that is not on the hospital premises, even if that outpatient department or clinic is accorded provider-based status. Therefore, we are proposing as the third prerequisite for a hospital to receive payment for ''incident to'' services under section 1861(s)(2)(B) of the Act, when these services are furnished at a hospital outpatient department or clinic that HCFA designates as provider-based: that the ''incident to'' services and supplies always be furnished under the direct supervision of a physician.

Unless the three prerequisites are met, we are proposing to continue to regard a clinic, even if it is owned or operated by a hospital, as a physician office or physician clinic for Medicare payment purposes. Payment for services and supplies incident to physician services that are furnished to Medicare beneficiaries at that site would only be paid in accordance with section 1848 and section 1861(s)(2)(A) of the Act, and payment would be subject to Medicare physician fee schedule payment policies and regulations (part 410; part 414).

2. Prerequisites for Payment for Hospital or Critical Access Hospital Diagnostic Services Furnished to Outpatients

Prerequisites for payment for diagnostic services furnished to hospital outpatients are addressed in § 410.28. We are proposing to add a new paragraph to the regulation that would require, at a minimum, a general level of physician supervision, and in some cases, direct or personal physician supervision, when diagnostic x-ray tests and other diagnostic tests are furnished at a hospital outpatient department or clinic that HCFA has determined meets the criteria and obligations of a provider-based entity in accordance with § 413.65. The definitions of general, direct, and personal supervision are contained in § 410.32. Although the levels of supervision defined in § 410.32 apply specifically to diagnostic x-ray and other tests that are payable under the Medicare physician fee schedule, we believe the same levels of supervision are equally relevant and reasonable and necessary to ensure that beneficiary health and safety are protected and that diagnostic x-ray and other diagnostic tests are safe and effective when they are furnished at a hospital outpatient department or clinic that HCFA has designated to be provider-based.

We are also proposing to exclude from the supervision requirement in provider-based outpatient settings the same three types of diagnostic tests that are excluded from the supervision requirement under the physician fee schedule:

- Diagnostic mammography procedures, which are regulated by the Food and Drug Administration.
- Diagnostic tests personally furnished by a ''qualified audiologist'' as defined in section 1861(ll)(3) of the Act. These include ''audiology services'' as defined in section 1861(ll)(2) of the Act. We exclude these diagnostic tests from the physician supervision requirement because the Congress has defined these services without requiring physician supervision of their performance.
- Diagnostic psychological testing services personally performed by a qualified psychologist practicing independently of an institution, agency, or physician office as currently defined in section 2070.2 of the Medicare Carriers Manual (HCFA Pub. 14–3). These services are distinguished from services of a clinical psychologist, which are covered under section 1861(ii) of the Act, rather than section 1861(s)(3).

We are proposing to coordinate changes to the physician supervision requirements for diagnostic tests performed in outpatient settings that HCFA has designated to be provider-based with changes made to these requirements under the Medicare physician fee schedule. Refer to the final rule governing the 1998 physician fee schedule that was published in the October 31, 1997 **Federal Register** (''Medicare Program; Revisions to Payment Policies and Adjustments to the Relative Value Units Under the Physician Fee Schedule, Other Part B Payment Policies, and Establishment of the Clinical Psychologist Fee Schedule for Calendar Year 1998'' (BPD–884–FC) (62 FR 59048)) for a full discussion. Implementing instructions for physician supervision of diagnostic tests are being developed. We note that these implementing instructions will contain revisions in the supervision levels required for many ultrasound services, stress tests, and some other services.

When diagnostic x-rays and other diagnostic tests are performed at a hospital-owned and/or operated office or clinic that is off-site and that HCFA does *not* designate as provider-based, we are proposing to pay for these services under the provisions of the Medicare physician fee schedule and the requirements of § 410.32 or under the provisions of § 410.33, if applicable.

3. Payment for Ambulatory Surgical Services

Upon implementation of the hospital outpatient PPS, Medicare payment for resource costs incurred in connection with performing ambulatory surgical procedures would be made either under the provisions of the hospital outpatient PPS; or, under the benefit established at section 1832(a)(2)(F) of the Act for facility services furnished by an approved ASC in connection with surgical procedures specified by the Secretary; or, under the physician fee schedule as established under section 1848 of the Act.

When ambulatory surgery is performed at the hospital on Medicare beneficiaries who are registered at the hospital as outpatients, Medicare would allow payment under the outpatient PPS, as explained in this proposed rule. However, Medicare would make payment under the outpatient PPS for surgical procedures performed at an off-site clinic that the hospital owns and operates and for which it submits claims only if the off-site clinic has been designated by HCFA as a department of the hospital in accordance with proposed § 413.65.

Alternatively, if the hospital-owned off-site facility is certified or accredited in accordance with ASC conditions of coverage and the requirements at part 416, Medicare would make payment for covered surgical procedures performed at the off-site facility under the ASC benefit.

However, for Medicare payment purposes, we consider an off-site office, clinic, organization, or facility that is owned and operated by a hospital but that does not meet the requirements at proposed § 413.65 or in part 416, to be a physician office or clinic, and Medicare payment for surgical procedures performed at that site would be limited to what Medicare allows for physician services furnished in connection with the surgical procedure under the Medicare physician fee schedule.

VII. MedPAC Recommendations

We reviewed the March 1998 report submitted by MedPAC to the Congress and gave its recommendations careful consideration in establishing the framework for the outpatient PPS that is the subject of this proposed rule. We responded earlier to several MedPAC recommendations that pertained directly to specific features of the outpatient PPS. In this section, we address the more general MedPAC recommendations on hospital outpatient payment policies.

Recommendation: MedPAC expresses its concern about the effects of inappropriate payment levels that could, if they are too low, restrict beneficiary access to care or prompt shifts of services for financial rather than clinical reasons, or that could, if they are too high, stimulate growth in the volume of outpatient services that is unrelated to patient needs. MedPAC states that the initial level of payment established in the BBA is a reasonable starting point for the outpatient PPS, but recommends that the Secretary monitor access to hospital outpatient services to ensure that the aggregate level of payment under the outpatient PPS is appropriate.

Response: We agree with MedPAC that monitoring service patterns not only in hospital outpatient departments but across all ambulatory settings subsequent to implementation of the outpatient PPS is essential in order to detect sudden changes and to identify variant trends in where services are being furnished to Medicare beneficiaries. As is MedPAC, we too are aware of how vividly any differences in payment for services furnished in different ambulatory settings will be revealed once the outpatient PPS is implemented, and we expect that these differences will, not surprisingly, precipitate shifts in services from one setting to another. It is the recognition of this likely outcome that makes it all the more urgent that we resolve the dilemma posed by two conflicting policy determinations raised by MedPAC: whether to set Medicare payments to reflect the cost of providing a service regardless of where the service is furnished or whether to set Medicare payments to acknowledge that the site where a service is furnished could affect the cost of furnishing the service. As we discuss below, we clearly are inclined toward a position that Medicare should determine payment on the basis of the service that is furnished rather on the setting where that service is furnished, but there are many factors still to be considered before making such a determination final. In the meantime, we believe that the adjustments provided for under the outpatient PPS will contribute to ensuring that Medicare is paying adequately for services, especially in areas where a hospital is the only provider of services to which beneficiaries have access. We particularly welcome comments and suggestions regarding methods by which we can enhance our monitoring of service delivery patterns to ensure that the outpatient PPS is not adversely affecting beneficiary access to hospital outpatient care in accordance with MedPAC's recommendation. We agree with MedPAC's concern that payment levels under the outpatient PPS be sufficient to support the provision of services, especially in areas where a hospital is the only provider of such services, but that payment levels under the outpatient PPS not exceed payments for the same services at other ambulatory sites to such a degree as to cause shifts in where services are provided for financial rather than clinical reasons.

Recommendation: MedPAC recommends that HCFA continue to investigate service classification systems that could be applied consistently to all ambulatory care settings. In its 1998 report to Congress, MedPAC expresses concern about the impact on service delivery of paying different amounts for the same service based on where the service is furnished. MedPAC appears to favor Medicare ambulatory care payment systems that are standardized across hospital outpatient, physician office, and ASC settings. MedPAC equates ''standardized'' with ''policies that are comparable for the same service, regardless of setting,'' (p. 83) and ''* * * consistency of payment across all ambulatory settings'' (p. 84).

Response: In principle, we agree that establishing Medicare payment

uniformity across ambulatory care settings is important. We have, to the extent permitted by the statute, incorporated into the outpatient PPS elements of Medicare payment policy for ASCs and for physician services.

Upon implementation of the outpatient PPS, the same unit of payment (HCPCS codes and descriptors) will be used for all three settings. Packaging under the outpatient PPS parallels that for ASCs. At least initially, volume control under the outpatient PPS parallels that which is applied to physician services. The policy for discounting multiple procedures will be comparable under the outpatient PPS, the ASC benefit, and the physician fee schedule. APC groups will be used to set rates for ASC payments and for hospital outpatient surgical services, and we propose to pay for the same surgical procedures in both settings. Notwithstanding these similarities, payment rates for most procedures will not be the same for ASCs and under the outpatient PPS. We use different data and methods to set rates for ASC services, for physician services, and for hospital outpatient services. The latter is attributable primarily to the fact that the statute sets forth criteria that are to be considered when setting payment mechanisms that are specific to each site of service.

Several fundamental issues must be addressed before we achieve the goal of making consistent payment for the same service across all ambulatory sites of service. First, consensus must be reached on what constitutes ''consistent payment.'' Even MedPAC equivocates on this point, noting that while it believes that ''Medicare's payment should reflect the cost of efficiently providing a service, regardless of where it is delivered * * * (b)ecause of access or quality concerns * * * it may be appropriate to continue to pay different amounts for the same service, depending on the setting in which it is furnished.'' Does ''consistent'' or ''comparable'' payment mean the *same* payment for a service regardless of setting? Or would consistency be achieved by using the same group weights for hospital outpatient and ASC payment rates even though we used site-specific conversion factors, resulting in different payment rates? Should we use ASC groups as the basis for setting payments for physician services? Is there a single index that is appropriate to standardize variations in costs attributable solely to geographical differences? And which legislative changes would be required to standardize payment for services across ambulatory settings? These are but a few of the issues and options that we and stakeholders across the spectrum of ambulatory care must thoroughly examine and analyze as we move towards standardizing payments across ambulatory sites of service. We solicit comments on this issue, on options to be considered in restructuring Medicare payment provisions towards the goal of establishing payment uniformity across ambulatory sites, and on strategies for achieving consensus on the definition of both goals and the means of attaining them.

VIII. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the provisions summarized below that contain information collection requirements:

Section 413.65 Requirements for a Determination That a Facility or an Organization is a Department of a Provider or a Provider-Based Entity

Section 413.65(c)(1) and (c)(2) states that a main provider that acquires a facility or organization for which it wishes to claim provider-based status, including any physician offices that a hospital wishes to operate as a hospital outpatient department or clinic, must report its acquisition of the facility or organization to HCFA and must furnish all information needed for a determination as to whether the facility or organization meets the requirements in paragraph (d) of this section for provider-based status. This requirement applies, however, only if the facility or organization is located off the campus of the provider, or inclusion of the costs of the facility or organization on the provider's cost report would increase the total costs on the report by at least 5 percent. Furthermore, a main provider that has had one or more entities considered provider-based also must report to HCFA any material change in the relationship between it and any provider-based facility or organization, such as a change in ownership of the facility or organization or entry into a new or different management contract that could affect the provider-based status of the facility or organization.

The burden associated with this requirement is the time for the main provider to report its acquisition to HCFA, furnish all information needed for a determination, report to HCFA any material change in the relationship between it and any provider-based facility or organization, such as a change in ownership of the facility or organization or entry into a new or different management contract that could affect the provider-based status of the facility or organization. It is estimated that 105 main providers will take 10 hours for a total of 1,050 hours.

Section 419.42 Hospital Election To Reduce Copayment

Section 419.42(b) and (c) states that a hospital must notify its fiscal intermediary of its election to reduce copayments no later than 90 days prior to the start of the calendar year. The hospital's election must be properly documented. It must specifically identify the ambulatory payment classification to which it applies and the copayment level (within the limits identified below) that the hospital has selected for each group.

The burden associated with these requirements is the time it takes a hospital to compile, review, and analyze data for both revenues and copayments; prepare and present the data to the hospital board; make a business decision as to whether the hospital would elect to reduce copayments; and then notify its fiscal intermediary of its election. A hospital would notify its fiscal intermediary of its election to reduce copayments only if there were other providers, in close proximity, that would attract a majority of the hospital's business if they did not reduce their copayments. Since hospitals do not want to lose money by absorbing copayments, we anticipate that this requirement will affect 750 hospitals and take them 10 hours each for a total of 7,500 hours.

Section 419.42(e) states that the hospital may advertise and otherwise disseminate information concerning the reduced level(s) of coinsurance that it has elected.

The burden associated with this requirement is the time for the hospital to disseminate information concerning its coinsurance election. It is estimated that 750 hospitals will each take 10 hours annually to disseminate this information via newsletters and information sessions at senior citizen centers for a total of 7,500 hours.

While the information collection requirements listed below are subject to the Paperwork Reduction Act, the burden associated with these requirements is captured under § 413.65(c)(1) and (c)(2).

Section 413.65(b)(2) states that a provider or a facility or organization must contact HCFA and the facility or organization must be determined by HCFA to be provider-based before the main provider begins billing for services of the facility or organization as if they were furnished by a department of the provider-based entity, or before it includes costs of those services on its cost report.

Section 413.65(d)(7)(i) requires that the facility or organization demonstrates a high level of integration with the main provider by showing that it meets all of the other provider-based criteria, and demonstrates that it serves the same patient population as the main provider, either by submitting records such as common patient lists and/or demographic data showing that a high percentage of patients of both the main provider and the applicant entity come from the same geographic area, or by submitting data substantiating that the patients served by the entity also receive services from the main provider (for example, the patients of an RHC receive inpatient hospital services from the main provider).

While the information collection requirements listed below are subject to the Paperwork Reduction Act, we believe the burden associated with these requirements is not subject to the Act, as defined by 5 CFR 1320.3(b)(2), because the time, effort, and financial resources necessary to comply with these requirements would be incurred by persons in the normal course of their activities.

Section 413.65(g)(7) states that when a Medicare beneficiary is treated in a hospital outpatient department or hospital-based entity, the hospital has a duty to notify the beneficiary, prior to the delivery of services, of the beneficiary's potential financial liability (that is, a coinsurance liability for a facility visit as well as for the physician service).

We believe the information collection requirement below is exempt from the Paperwork Reduction Act, as defined by 5 CFR 1320.4(a)(2), since this activity is pursuant to the conduct of an investigation or audit against specific individuals or entities.

Section 413.65(i)(1) states that if HCFA determines that a provider has been inappropriately billing Medicare for services furnished in a physician office or other facility or organization as if they had been furnished in a hospital outpatient department or other department of a provider or in a provider-based entity, HCFA stops all payments to the provider for outpatient services until the provider can demonstrate which payments are proper.

The table below indicates the annual number of responses for each regulation section in this proposed rule containing information collection requirements, the average burden per response in minutes or hours, and the total annual burden hours.

ESTIMATED ANNUAL BURDEN

CFR section	Responses	Average burden per response (hours)	Annual burden hours
413.65(c)(1) and (c)(2)	105	10	1,050
419.42(b) and (d)	750	10	7,500
419.42(f)	750	10	7,500
Total			16,050

We have submitted a copy of this proposed rule to OMB for its review of the information collection requirements. These requirements are not effective until they have been approved by OMB. A notice will be published in the **Federal Register** when approval is obtained.

If you comment on any of these information collection and record keeping requirements, please mail copies directly to the following:

Health Care Financing Administration, Office of Information Services, Information Technology Investment Management Group, Division of HCFA Enterprise Standards, Room C2–26–17, 7500 Security Boulevard, Baltimore, MD 21244–1850, Attn: Louis Blank HCFA–1005–P, Fax number: (410) 786–1415 and,

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn.: Allison Herron Eydt, HCFA Desk Officer, Fax numbers: (202) 395–6974 or (202) 395–5167.

IX. Response to Comments

Because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the ''DATES'' section of this preamble, and, if we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

X. Regulatory Impact Analysis

A. Introduction

We have examined the impacts of this proposed rule as required by Executive Order 12866, the Unfunded Mandates Reform Act of 1995, and the Regulatory Flexibility Act (RFA) (Public Law 96–354). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more annually). Because the projected savings resulting from this proposed rule are

expected to exceed $100 million, it is considered a major rule.

The Unfunded Mandates Reform Act of 1995 also requires (in section 202) that agencies prepare an assessment of anticipated costs and benefits for any rule that may result in an annual expenditure by State, local, or tribal governments, in the aggregate, or by the private sector, of $100 million. This proposed rule does not mandate any requirements for State, local, or tribal governments. However, our estimations indicate that the loss of income to the private sector as a result of this rule should exceed $300 million total to all hospitals.

We generally prepare a regulatory flexibility analysis that is consistent with the RFA (5 U.S.C. 601 through 612), unless we certify that a proposed rule would not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, we consider all hospitals to be small entities.

Also, section 1102(b) of the Social Security Act requires us to prepare a regulatory impact analysis for any proposed rule that may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 603 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA). Section 601(g) of the Social Security Amendments of 1983 (Public Law 98–21) designated hospitals in certain New England counties as belonging to the adjacent NECMA. Thus, for purposes of the proposed prospective payment system, we classify these hospitals as urban hospitals.

B. Estimated Impact on Medicare Program

According to HCFA's Office of the Actuary, the benefit impacts of the hospital outpatient PPS (including elimination of the formula-driven overpayment (FDO) effective as of October 1, 1997, extension of the 10 percent reduction in payments for hospital outpatient capital cost and the 5.8 percent reduction for outpatient services paid on a cost basis through CY 1999, and the implementation of a PPS for hospital outpatient services on January 1, 1999 would be as follows:

Fiscal year	Impact ($ millions)
1998	−940
1999	−1650
2000	−1330
2001	−1070
2002	−990
2003	−680

The use of the national median of the charges for PPS services to establish the unadjusted copayment amount would have resulted in the beneficiaries paying 6.9 percent less in coinsurance payments in 1999 than what they would have been expected to pay otherwise. It was assumed that there would have been a behavioral offset by the hospitals of 10 percent of the coinsurance reduction. It was assumed that 45 percent of this offset would apply to the services subject to the PPS and, therefore, would have been included in setting the 1999 conversion factor. The remaining 55 percent of the offset would be reflected in expenditures for non-PPS services with both the beneficiary and Medicare absorbing this impact. With the delay in implementation of the outpatient PPS, the behavioral offset will not occur in 1999, and, therefore, there will be slightly higher program savings.

C. Objectives

The primary objective of the proposed prospective payment system is to simplify the payment system while at the same time ensuring that payments are sufficient to adequately compensate hospitals for their legitimate costs. In addition, we share national goals of deficit reduction and restraints on government spending in general.

We believe the proposed changes would further each of these goals while maintaining the financial viability of the hospital industry and ensuring access to high quality health care for Medicare beneficiaries. We expect that these proposed changes would ensure that the outcomes of this payment system are reasonable and equitable while avoiding or minimizing unintended adverse consequences.

D. Limitations of our Analysis

The following quantitative analysis presents the projected effects of our proposed policy changes, as well as statutory changes, on various hospital groups. We use the best data available; in addition, we do not make adjustments for future changes in such variables as volume and intensity. As we have done in previous proposed rules, we are soliciting comments and information about the anticipated effects of these changes on hospitals and our methodology for estimating them.

E. Hospitals Included in and Excluded From the Prospective Payment System

The outpatient prospective payment system encompasses nearly all hospitals that participate in the Medicare program. However, those services furnished by Maryland hospitals that are paid under a cost containment waiver in accordance with section 1814(b)(3) of the Act are excluded from the PPS. Critical access hospitals (CAHs) are also excluded and are paid at cost under section 1834(g).

F. Quantitative Impact Analysis of the Proposed Policy Changes Under the Prospective Payment System for Operating Costs and Capital Costs

Basis and Methodology of Estimates

The data used in developing the quantitative analyses presented below are taken from the CY 1996 cost and charge data and the most current provider-specific file that is used for payment purposes. Our analysis has several qualifications. First, we draw upon various sources for the data used to categorize hospitals in the tables. In some cases, there is a fair degree of variation in the data from different sources. We have attempted to construct these variables with the best available source overall. For individual hospitals, however, some miscategorizations are possible.

Using CY 1996 cost and charge data, we simulated payments using the current and proposed payment methodologies. We used both single and multiple bills to calculate current and proposed Medicare and beneficiary hospital outpatient payment amounts. Both current and proposed payment estimates include operating and capital costs. The exempted Maryland hospitals were excluded from the simulations; however, we included the 10 cancer hospitals that will be paid under the proposed system.

We also trimmed outlier hospitals from the impact analysis because we had indications that hospitals with extreme unit costs would not allow us to assess the impacts among the various classes of hospitals accurately. First, we identified all the outlier hospitals by using an edit of three standard deviations from the mean of the logged unit costs. Trimming the data in this manner ensures that only the hospitals with extremely high and low costs are eliminated from the impacts. In doing this, we removed 83 hospitals of which 32 hospitals had extremely low unit costs and 51 hospitals had extremely

high unit costs. We conducted a thorough analysis of these hospitals to ensure that we did not remove any particular type of hospital (for example, teaching hospitals) that would further harm the integrity of the data. We speculate many of these hospitals are not coding accurately, and we will continue to perform further analysis in this area after implementation of the new APC system.

After removing the 54 exempted Maryland hospitals, outlier hospitals, and hospitals for which we could not identify payment variables, we included 5,419 hospitals in our analysis. The impact analysis focuses on this set of hospitals. The table below demonstrates the results of our analysis. The table categorizes hospitals by various geographic and special payment consideration groups to illustrate the varying impacts on different types of hospitals. The first column represents the number of hospitals in each category. The second column is the hospitals' Medicare outpatient payments as a percentage of the hospitals' total Medicare payment. The third column shows the percentage change in Medicare outpatient payments comparing the current and proposed payment systems. The fourth column shows the change in total Medicare payments, resulting from implementing the PPS for outpatient services.

The top row of the table shows the overall impact on the 5,419 hospitals included in the analysis. We included as much of the data as possible to the extent that we were able to capture all the provider information necessary to determine payment. Further, our estimates include the same set of services for both current and proposed APC payments so that we could determine the impact as accurately as possible. Since payment under the proposed APC system can only be determined if bills are accurately coded, the data upon which the impacts were developed do not reflect all CY 1996 hospital outpatient services, but only those that were coded using valid HCPCS.

The second row identifies the hospitals in our analysis with the exception of psychiatric, long-term care, children, and rehabilitation hospitals, which account for 4,864 hospitals.

The next four rows of the table contain hospitals categorized according to their geographic location (all urban, which is further divided into large urban and other urban, or rural). There are 2,677 hospitals located in urban areas (MSAs or NECMAs) included in our analysis. Among these, there are 1,516 hospitals located in large urban areas (populations over 1 million), and 1,161 hospitals in other urban areas (populations of 1 million or fewer). In addition, there are 2,187 hospitals in rural areas. The next two groupings are by bed-size categories, shown separately for urban and rural hospitals. The next category includes the volume of outpatient services, also shown separately for urban and rural hospitals. The final groupings by geographic location are by census divisions, also shown separately for urban and rural hospitals.

The next three groupings examine the impacts of the proposed changes on hospitals grouped by whether or not they have residency programs (teaching hospitals that receive an indirect medical education (IME) adjustment), receive disproportionate share hospital (DSH) payments, or some combination of these two adjustments. There are 3,847 non-teaching hospitals in our analysis, 766 teaching hospitals with fewer than 100 residents, and 250 teaching hospitals with 100 or more residents.

In the DSH categories, hospitals are grouped according to their DSH payment status. The next category groups hospitals considered urban after geographic reclassification, in terms of whether they receive the IME adjustment, the DSH adjustment, both, or neither. The next five rows examine the impacts of the proposed changes on rural hospitals by special payment groups (rural referral centers (RRCs), sole community hospitals/essential access community hospitals (SCHs/EACHs), Medicare dependent hospitals (MDHs), and SCHs and RRCs), as well as rural hospitals not receiving a special payment designation. The RRCs (168), SCH/EACHs (625), MDHs (365), and SCH and RRCs (55) shown here were not reclassified for purposes of the standardized amount.

The next grouping is based on type of ownership. These data are taken primarily from the FY 1995 Medicare cost report files, if available (otherwise, FY 1994 data are used).

The next groupings are the specialty hospitals. The first set includes the categorizations of eye and ear hospitals and trauma hospitals (hospitals having a level one trauma center) and cancer hospitals. The final groupings are the TEFRA hospitals, specifically rehabilitation, psychiatric, long-term care, and children hospitals.

G. Estimated Impact of the New APC System

Column 3 compares our estimate of payments, incorporating statutory and policy changes reflected in this proposed rule for CY 1996, to our estimate of payments in CY 1996 under the current payment system. Percent differences between current and proposed payment reflect the combined impact of a proportionally equal reduction in payments due to the calculation of the conversion factor and distributional differences attributable to variation in cost and charge structures among hospitals. The methodology described in section 1833(t)(3)(C) of the Act outlining the calculation of the conversion factor reduces payment to hospitals overall by 3.8 percent relative to current law. As noted, section 1833(t)(3)(C) of the Act requires us to set the conversion factor so that total 1999 payments to hospitals under the proposed PPS system equal Medicare payment amounts as calculated under the current payment system plus beneficiary copayments as calculated under the proposed system (20 percent of the APC median charge or, at minimum, 20 percent of the APC rate). The 3.8 percent loss implies that the difference between the median and charges higher than the median was proportionally larger than the difference between the median and charges lower than the median. Because this reduction is incorporated into the conversion factor, the 3.8 percent is distributed among hospitals proportional to their total payments. After removing the effect of the conversion factor calculation on total payments, the remaining percent differences demonstrate the redistribution of payments among hospitals and can be attributed to variation in both costs and charge structures. Variation in costs among hospitals results in differences between current and proposed Medicare payments, and variation in charge structures results in differences between current and proposed beneficiary copayment.

Redistributions may also occur as a result of current payment methods. Total Medicare outpatient payments are less than reported total costs because (in addition to the 5.8 and 10 percent reductions for operating and capital costs) the blended payment methods applicable to many surgical and diagnostic services often result in payments that are less than reported costs. Other services such as medical visits, chemotherapy services, partial hospitalization services, and non-ASC approved surgeries are paid based on hospital costs. The new system redistributes the current total Medicare payments, based in part on cost-based payments and in part on blended

payment amounts, across all services. Hospitals, in the aggregate, will receive proportionately less for services that are currently paid based on costs and more for services that had been paid under blended payment methods.

The impact on TEFRA hospitals is shown separately at the end of the table; however, these hospitals were not included in determining the impact on any of the other categories (for example, geographic location, bed size, volume, etc.). These hospitals demonstrated a very low service mix, but an average unit cost that is only somewhat smaller than the national average. We believe that billing practices may account for this phenomenon. Some TEFRA hospitals appear to under-code HCPCS and units. This may be because correct coding is not required for payment or because they bill an all-inclusive rate. Undercoding or billing an all-inclusive rate could account for their low volume, low service mix, and almost average cost per unit. We expect that once these hospitals begin to code HCPCS according to the new payment system, new payments will better reflect current payments.

In general, differences among hospital classifications for short-term acute care hospitals were relatively small. That is, payments under the proposed outpatient system were within a few percentage points of payments made under current law. The following discussion highlights some of the variation in payments among hospital classifications.

Based on comparing current and proposed payment estimates, minor teaching hospitals lose 1.8 percent, while major teaching hospitals experience a reduction of 9.4 percent. Non-teaching hospitals experience a decrease of 3.1 percent. However, major teaching hospitals gain less of their total Medicare income (9.2 percent) from outpatient services than the national average (10 percent). This results in a less than 1 percent loss in their total Medicare income.

Hospitals with a high percentage of low income patients (disproportionate share patient percentage ≤ 0.35) appear to experience payment reductions of 6.8 percent relative to current law. These hospitals have lower than average volume, and, like major teaching hospitals, they receive a smaller than average percent of their Medicare income from outpatient services.

Rural hospitals would lose about 5.2 percent and large urban hospitals would lose about 5.0 percent under the new system while other urban hospitals would lose 0.9 percent. These small differences illustrate fairly equitable payment among these geographical settings. However, rural hospitals get a greater percentage of their Medicare income (14.7 percent) from outpatient services compared to the national average of 10 percent.

Low-volume hospitals appear to lose a large percentage of their payments under the new payment system (17 percent for rural and 15.6 percent for urban hospitals with less than 5,000 units of service). We believe several factors are contributing to this outcome, including undercoding, lack of economies of scale, and underpayment due to the reliance on the median instead of the geometric mean in the calculation of APC weights. The majority of these hospitals (about 75 percent) are rural. These hospitals also have a service mix (1.03) lower than the national average (1.45) and higher than average hospital cost per unit standardized for service mix. For these small hospitals, some of the higher standardized unit costs could be attributed to economies of scale. These low-volume rural hospitals also receive a greater percentage of their Medicare income (18.2 percent) from outpatient services than the average. SCHs and MDHs comprise about 60 percent of these low-volume rural hospitals.

As discussed previously in section V.I, the Adjustments section, we are particularly concerned about the potential impact on the approximately 60 percent of low-volume rural hospitals that are sole community hospitals or Medicare-dependent hospitals. As previously discussed, one option would be to phase-in the outpatient PPS for low-volume Medicare-dependent and sole community hospitals by paying a portion of the payment based on PPS rates and a portion based on the current payment system. For example, payment could be based on 75 percent of payments under the current system and 25 percent on PPS rates in the first year, 50 percent current system payments and 50 percent PPS rates in the second year, 25 percent current system payments and 75 percent PPS rates in the third year, and completely on PPS rates in subsequent years. If such an approach were adopted, the impact on Medicare outpatient payment for these hospitals would be as follows:

ESTIMATED IMPACT OF A TRANSITION POLICY ON MEDICARE OUTPATIENT PAYMENTS FOR MEDICARE-DEPENDENT AND SOLE COMMUNITY HOSPITALS

[In percent]

	Year 1	Year 2	Year 3	Year 4
MDH	−2.1	−4.3	−6.4	−8.5
SCH	−1.7	−3.3	−5.0	−6.7
SCH/RRC	−0.5	−1.0	−1.6	−2.1

Another option discussed earlier in the adjustments section would phase-in outpatient PPS if a low-volume sole community or Medicare-dependent hospital has a negative Medicare margin for outpatient services. For example, payment could be based on the amount payable under outpatient PPS plus a percentage of the difference between those amounts and the amounts payable under the current system. The percentage of the difference that would be payable could phase down, for example, 75 percent in the first year, 50 percent in the second year, 25 percent in the third year, and no additional payment in subsequent years. We solicit comments on these and other alternatives we could consider.

As noted above, rural hospitals lose a larger percent of their payments than urban hospitals. Among the census divisions, rural New England hospitals experience the largest negative payment impact of 13.6 percent. This could be attributed to higher non-labor costs in New England. West North Central hospitals also would experience a 7.7 percent payment loss.

Urban census division breakouts reveal that Middle Atlantic urban hospitals lose 11.3 percent of payments while the other urban census regions gain or lose modestly.

Hospitals located in Puerto Rico gain because of the change in the beneficiary copayment. Previously these hospitals received 20 percent of their charges from the beneficiary, whereas under the

new PPS they would receive 20 percent of the APC median charge or, at minimum, they would receive 20 percent of the payment rate. Hospitals in Puerto Rico gain under the new proposed system because 20 percent of their charges are lower than 20 percent of the APC median charges or 20 percent of the rates.

Among special categories of rural hospitals, MDHs and SCHs/EACHs would experience decreases of 8.5 and 6.7 percent, respectively. Some of this decrease may be attributed to the impact on low-volume rural hospitals.

Cancer hospitals experience a 29.2 percent loss. Several factors may contribute to this loss. Under-coding could be a factor contributing to the percentage loss. In addition, the current requirements for batch billing of services such as chemotherapy and radiation therapy and the fact that we used only single procedure bills to calculate group weights may also have contributed to the impact on these hospitals. Further analysis will be conducted to determine if current coding practices explain the negative impact. We will be verifying the accuracy of the rates for these types of procedures. Specifically, the APC weights were calculated using single bill procedures. Using single bill procedures to compute a weight for services which are not typically billed as a single procedure could result in rates that are not accurate for these services. We will verify the accuracy of the rates for these types of procedures by analyzing the costs from the multiple bills. If further analysis reveals that cancer hospitals would be unduly harmed because of the new outpatient PPS, we will consider whether an adjustment or perhaps a transition period is needed to moderate the impact. By statute, any adjustment would have to be budget neutral. Until further analysis can be conducted we are not proposing an adjustment for cancer hospitals.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

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CHANGES FOR
OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

	Number of hospitals (1)	Outpatient percent (2)	Percent change in Medicare outpatient payments (3)	Percent change in total Medicare payments (4)
ALL HOSPITALS	5,419	9.9	-3.8	-0.4
NON-TEFRA HOSPITALS	4,864	10.0	-3.7	-0.4
NON-TEFRA HOSPITALS: LOCATION				
GEOGRAPHIC LOCATION				
URBAN HOSPITALS	2,677	9.3	-3.3	-0.3
LARGE URBAN AREAS	1,516	9.1	-5.0	-0.5
OTHER URBAN AREAS	1,161	9.6	-0.9	-0.1
RURAL HOSPITALS	2,187	14.7	-5.2	-0.8
BED SIZE (URBAN)				
0- 99 BEDS	654	15.5	-7.4	-1.1
100-199 BEDS	917	10.4	-2.5	-0.3
200-299 BEDS	542	9.2	-0.7	-0.1
300-499 BEDS	425	8.6	-3.3	-0.3
500 OR MORE BEDS	139	8.3	-7.0	-0.6
BED SIZE (RURAL)				
0- 49 BEDS	1,149	19.6	-9.8	-1.9
50- 99 BEDS	644	15.5	-6.9	-1.1
100-149 BEDS	229	13.5	-4.6	-0.6
150-199 BEDS	91	13.0	-2.0	-0.3
200 OR MORE BEDS	74	11.4	0.1	0.0
VOLUME (URBAN)				
0- 4,999 UNITS	278	12.1	-15.6	-1.9
5,000- 10,999 UNITS	442	9.8	-6.3	-0.6

	Number of hospitals (1)	Outpatient percent (2)	Percent change in Medicare outpatient payments (3)	Percent change in total Medicare payments (4)
11,000- 20,999 UNITS	599	9.1	-5.8	-0.5
21,000- 42,999 UNITS	780	8.7	-3.6	-0.3
43,000 OR MORE UNITS	578	9.7	-2.0	-0.2
VOLUME (RURAL)				
0- 4,999 UNITS	816	18.2	-17.0	-3.1
5,000- 10,999 UNITS	694	15.8	-10.0	-1.6
11,000- 20,999 UNITS	420	14.6	-5.8	-0.8
21,000- 42,999 UNITS	215	13.5	-1.8	-0.2
43,000 OR MORE UNITS	42	13.2	5.3	0.7
URBAN BY CENSUS DIV.				
NEW ENGLAND	152	10.7	-4.9	-0.5
MIDDLE ATLANTIC	399	8.3	-11.3	-0.9
SOUTH ATLANTIC	400	8.6	-3.8	-0.3
EAST NORTH CENTRAL	451	10.7	-0.5	-0.1
EAST SOUTH CENTRAL	158	7.9	0.9	0.1
WEST NORTH CENTRAL	189	9.5	-1.6	-0.2
WEST SOUTH CENTRAL	340	9.7	-2.2	-0.2
MOUNTAIN	122	10.2	1.3	0.1
PACIFIC	429	9.3	0.1	0.0
PUERTO RICO	37	6.8	8.3	8.6
RURAL BY CENSUS DIV.				
NEW ENGLAND	56	16.9	-13.6	-2.3
MIDDLE ATLANTIC	81	13.5	-1.9	-0.3
SOUTH ATLANTIC	283	11.8	-5.7	-0.7
EAST NORTH CENTRAL	288	15.8	-3.3	-0.5
EAST SOUTH CENTRAL	267	11.2	-5.6	-0.6

	Number of hospitals (1)	Outpatient percent (2)	Percent change in Medicare outpatient payments (3)	Percent change in total Medicare payments (4)
WEST NORTH CENTRAL	516	19.6	-7.7	-1.5
WEST SOUTH CENTRAL	339	14.1	-6.1	-0.9
MOUNTAIN	216	16.7	-3.5	-0.6
PACIFIC	137	16.4	0.8	0.1
PUERTO RICO	4	6.6	34.6	2.3
TEACHING STATUS				
NON-TEACHING	3,847	11.2	-3.1	-0.3
FEWER THAN 100 RESIDENTS	766	9.1	-1.8	-0.2
100 OR MORE RESIDENTS	250	9.2	-9.4	-0.9
DISPROPORTIONATE SHARE PATIENT RATIO				
0	25	25.1	-0.3	-0.1
0.001- 0.099	916	10.3	-4.9	-0.5
0.100- 0.159	1,016	10.9	-0.9	-0.1
0.160- 0.229	977	10.2	-2.9	-0.3
0.230- 0.349	966	9.6	-4.2	-0.4
0.350 AND GREATER	964	9.2	-6.8	-0.6
URBAN TEACHING AND DSH				
BOTH TEACHING AND DSH	957	9.0	-4.6	-0.4
TEACHING AND NO DSH	2	19.8	-18.6	-3.7
NO TEACHING AND DSH	1,708	9.8	-1.9	-0.2
NO TEACHING AND NO DSH	10	28.6	40.8	11.7
RURAL HOSPITAL TYPES				
NONSPECIAL STATUS HOSPITALS	950	15.0	-6.6	-1.0
RRC	168	12.4	-1.9	-0.2
SCH/EACH	625	16.4	-6.7	-1.1

	Number of hospitals (1)	Outpatient percent (2)	Percent change in Medicare outpatient payments (3)	Percent change in total Medicare payments (4)
MDH	365	18.2	-8.5	-1.5
SCH/EACH AND RRC	55	13.7	-2.1	-0.3
TYPE OF OWNERSHIP				
VOLUNTARY	2,877	9.9	-4.0	-0.4
PROPRIETARY	680	7.9	-1.1	-0.1
GOVERNMENT	1,307	12.3	-4.0	-0.5
SPECIALTY HOSPITALS				
EYE AND EAR	13	33.6	1.4	0.5
TRAUMA	160	9.1	-5.9	-0.5
CANCER	10	22.0	-29.2	-6.4
TEFRA HOSPITALS:				
REHABILITATION	141	3.7	-24.1	-0.9
PSYCHIATRIC	304	10.4	-11.7	-1.2
LONG-TERM CARE	70	3.5	-4.1	-0.1
CHILDREN'S	40	9.9	-34.8	-3.4

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XI. Delay in Implementation Date

Like other public and private organizations that depend upon the smooth functioning of computer systems, the Medicare program faces the challenge making changes to assure that computers can recognize dates in the year 2000 and later. Computer programming, which has commonly employed only two digits to record the year in the date for transactions and other entries, will not be able to distinguish the year 2000 from the year 1900 without reprogramming. Such confusion in the context of Medicare enrollment and claims processing could create massive errors, as computers could mistakenly determine that beneficiaries are not eligible for benefits or that services were rendered before the effective date of benefit provisions.

For Medicare, achieving year 2000 (Y2K) compliance involves renovating all computer and information systems. The year 2000 especially affects HCFA because of our extensive reliance on multiple computer systems. More than 183 systems are used in administering the Medicare and Medicaid programs, and 98 of these are considered ''mission critical'' for establishing beneficiary eligibility and making payments to providers, plans, and states. Medicare is the most automated health care payer in the country. The Medicare program processes nearly one billion claims each year, or about 17 million transactions each week. Fully 98 percent of inpatient hospital and other Medicare Part A claims are processed electronically, as are 85 percent of physician and other Medicare Part B claims.

The renovation process is complicated because each piece in the systems used by Medicare, its 60-plus claims processing contractors, interfaces with state Medicaid programs, and some 1.6 million providers must be thoroughly reviewed and renovated by those responsible for each particular system. Programs must be tested, both alone and for the complicated interfaces among them. To fix only the Medicare systems, 49 million lines of code must be renovated. All Medicare-specific software must be renovated, and tested to assure that it continues to work with new versions of vendor-supplied software, including operating systems that drive the hardware. Some hardware must be upgraded, and our telecommunications equipment and software must be compliant. We must assure that all data exchanges with thousands of partners are compliant. Testing of year 2000 changes presents a far greater burden than testing of routine system changes because we must test multiple times on a range of different dates. For example, February 29, 2000 and March 1, 2000 must both be tested because CY 2000 is a leap year.

Because this process is necessary to keep program payments going out to beneficiaries and providers, year 2000 work must take precedence over other projects that require systems changes, including some Balanced Budget Act provisions. The Y2K project must be completed before other projects simply because activity on these other projects would divert resources from the Y2K project and could even compromise the effort to assure Y2K compliance if implemented in tandem. Many other private and public organizations, including most major insurance companies, have reached the same conclusion and are halting other projects involving information technology changes to clear the decks for the year 2000.

HCFA's independent year 2000 verification and validation contractor, Intermetrics, has advised the agency to delay all projects that could interfere with year 2000 work. Intermetrics specifically advised the agency to ''seek necessary relief from Congressional mandates, system transitions and version releases to allow near-term, focused attention to achieving Y2K compliant systems.'' This includes projects that are complex, or which would occur during a critical window between October 1999 and March 2000. Otherwise, they warned, ''many of your most critical system renovations have risk of significant schedule slippage.''

Implementation of outpatient PPS is one of the projects that must be delayed by the year 2000 system renovations, because it requires massive system changes. Major contractor systems will be affected: the Fiscal Intermediary Standard Systems (FISS), the Arkansas Part A Standard System (APASS), the Common Working File (CWF), the Outpatient Code Editor (OCE), and the various systems operated by Fiscal Intermediaries and their corporate entities. Several HCFA systems will also be affected, including the National Claims History (NCH), the Provider Statistical & Reimbursement System (PS&R), and the Electronic Data Interchange (EDI). The scope of the required changes is also substantial. Among the required changes are:

- Expansion of the claim record of FISS, APASS, EDI, NCH and CWF to accept and retain specific information related to how a service is being paid or why it's denied.
- Conversion of all claims history to correspond with expanded format.
- Rewriting the program for FISS to process claims using line item dates of service.
- Rewriting the program for CWF to accept non covered charges by claim and line item.
- Developing, installing and testing an outpatient PRICER which determines payment amounts based on the HCFA Common Procedural Codes (HCPCS).
- Revision of interfaces with the fiscal intermediaries, providers, Billing Agents, EDI, OCE, PS&R and NCH and create an interface for PRICER.
- Developing, installing and testing a program to calculate the variable co-insurance per payment code grouping for each provider who elects to accept a reduced co-insurance.
- Revision of all claims processing output and interfaces including: Medicare Summary Notices (MSN), Beneficiary Denial Letters (BDL), Explanation of Medicare Benefits (EOMB), Notice of Utilization (NOU), Remittance Advice (RA).

The consequence of all these required changes to basic systems will be to change the entire way Fiscal Intermediaries process and pay hospital outpatient and community mental health center claims. There is also a major impact on the many systems that are required to receive this revised output. Changes of this magnitude require massive testing by all of the systems maintainers as well as each Fiscal Intermediary. Additionally, the impact on the Fiscal Intermediary systems has a domino effect. The intermediaries are doing business for Medicare under the auspices of their respective corporate entities. These corporate systems must be modified to accept, edit and relay the new information necessary to process outpatient PPS claims. They are also working toward becoming millennium compliant and competing for the same resources to scope, program, test and rework these changes, as well as the multitude of other BBA changes and Y2K. In the light of this, HCFA has no choice but to suspend implementing such massive change while the Intermediaries, their respective corporate entities, the standard systems maintainers as well as the provider community are working diligently to become Y2K compliant. It would be irresponsible to continue activity that would create a real danger that basic enrollment and claims processing activities will be disrupted, with far worse consequences for providers and beneficiaries than delay in implementation of outpatient PPS will cause.

We analyzed whether existing systems could be used to mimic processing of bills under the outpatient PPS. In every case, there were insuperable obstacles. In no case, for example, could these other systems compute the coinsurance correctly: the other available systems compute coinsurance as 20 percent of charges or 20 percent of a fee schedule amount. We have therefore reluctantly concluded that there is no alternative to a delay in implementation. As previously noted, the outpatient PPS will be implemented as soon as possible after January 1, 2000. A notice of the anticipated implementation date will be published in the **Federal Register** at least 90 days in advance.

We expect that there will be no negative impact on hospitals generally from the delay in implementation. The effect on individual hospitals will, of course, vary depending on how their current cost-based reimbursement compares to the total payments they would receive under the proposed system. Hospitals altogether should receive about the same level of Medicare program payments under the existing payment system, as they would have received in program payments under the outpatient PPS. When beneficiary coinsurance is taken into account, we expect that hospitals generally will receive about 3.8 percent more in total payments under the existing payment system, than they would have received in total payments under the outpatient PPS. We should note that payment rates will be established at the level they would have been if the PPS had been implemented on January 1, 1999.

The major impact of the delay in implementation will be on beneficiaries who will continue to pay coinsurance based on 20 percent of the hospital's charges. In the aggregate, we estimate beneficiary coinsurance would have been 6.9 percent lower under the outpatient prospective payment system in 1999 than under the current system. Under the prospective payment system, coinsurance will be based on our estimate of the median coinsurance amount for each APC under the current system in 1999. In the aggregate, estimated median coinsurance amounts are 6.9 percent lower than estimated mean coinsurance amounts for each APC. The actual impact will depend on the extent to which hospitals raise their charges in 1999. For example, the impact on beneficiaries would be moderated if hospitals show restraint in increasing charges (which have been increasing more rapidly than cost). We will actively encourage hospitals to voluntarily restrain from increasing their current charges. The actual impact on a given beneficiary will also depend on the hospital's charge structure relative to national charge levels. A beneficiary receiving services from a hospital with relatively low charges could be advantaged by the delay whereas a hospital with relatively high charges would be disadvantaged by the delay. We note that the impact will not be carried over to the prospective payment system.

List of Subjects

42 CFR Part 409

Health facilities, Medicare.

42 CFR Part 410

Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Rural areas, X-rays.

42 CFR Part 411

Kidney diseases, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 419

Health facilities, Hospitals, Medicare.

42 CFR Part 489

Health facilities, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 498

Administrative practice and procedure, Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 1003

Administrative practice and procedure, Archives and records, grant program—social programs, Maternal and Child Health, Medicaid, Medicare, Penalties.

For the reasons set forth in the preamble, 42 CFR chapters IV and V would be amended as follows:

PART 409—HOSPITAL INSURANCE BENEFITS

A. Part 409 is amended as set forth below:

1. The authority citation for part 409 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395(hh)).

Subpart B—Inpatient Hospital Services and Inpatient Critical Access Hospital Services

2. In § 409.10, paragraph (b) is revised to read as follows:

§ 409.10 Included services.

* * * * *

(b) *Inpatient hospital services* does not include the following types of services:

(1) Post-hospital SNF care, as described in § 409.20, furnished by a hospital or a critical access hospital that has a swing-bed approval.

(2) Nursing facility services, described in § 440.155 of this chapter, that may be furnished as a Medicaid service under title XIX of the Act in a swing-bed hospital that has an approval to furnish nursing facility services.

(3) Physician services that meet the requirements of § 415.102(a) of this chapter for payment on a fee schedule basis.

(4) Physician assistant services, as defined in section 1861(s)(2)(K)(i) of the Act.

(5) Nurse practitioner and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

(6) Certified nurse mid-wife services, as defined in section 1861(gg) of the Act.

(7) Qualified psychologist services, as defined in section 1861(ii) of the Act.

(8) Services of an anesthetist, as defined in § 410.69 of this chapter.

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

B. Part 410 is amended as set forth below:

1. The authority citation for part 410 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395(hh)), unless otherwise indicated.

Subpart A—General Provisions

2. In § 410.2, the following definitions are added in alphabetical order to read as follows:

§ 410.2 Definitions.

As used in this part—

* * * * *

Encounter means a direct personal contact between a patient and a physician, or other person who is authorized by State licensure law and, if applicable, by hospital or CAH staff bylaws, to order or furnish hospital services for diagnosis or treatment of the patient.

* * * * *

Outpatient means a person who has not been admitted as an inpatient but who is registered on the hospital or CAH records as an outpatient and receives services (rather than supplies alone) directly from the hospital or CAH.

* * * * *

Subpart B—Medical and Other Health Services

3. In § 410.27, the section heading is revised, the introductory text to paragraph (a) is revised, the introductory text to paragraph (a)(1) is republished, and new paragraphs (a)(1)(iii), (e), and (f) are added to read as follows:

§ 410.27 Outpatient hospital services and supplies incident to a physician service: Conditions.

(a) Medicare Part B pays for hospital services and supplies furnished incident to a physician service to outpatients, including drugs and biologicals that cannot be self-administered, if—

(1) They are furnished—

* * * * *

(iii) In the hospital or at a location (other than an RHC or an FQHC) that HCFA designates as qualifying as a department of a provider under § 413.65 of this chapter; and

* * * * *

(e) Services furnished by an entity other than the hospital are subject to the limitations specified in § 410.39(a).

(f) Services furnished at a location (other than an RHC or an FQHC) that HCFA designates as having provider-based status under § 413.65 of this chapter must be under the direct supervision of a physician as defined in § 410.32(b)(3)(ii).

4. In § 410.28, paragraph (a)(4) is removed, paragraph (c) is redesignated as paragraph (d), and new paragraphs (c) and (e) are added to read as follows:

§ 410.28 Hospital or CAH diagnostic services furnished to outpatients: Conditions.

* * * * *

(c) Diagnostic services furnished by an entity other than the hospital or CAH are subject to the limitations specified in § 410.39(a).

* * * * *

(e) Medicare Part B makes payment under section 1833(t) of the Act for diagnostic tests performed at a facility (other than an RHC or an FQHC) that HCFA designates as having provider-based status only when the diagnostic tests are furnished under the appropriate level of physician supervision specified by HCFA in accordance with the definitions in § 410.32(b)(3)(i), (b)(3)(ii), and (b)(3)(iii).

5. A new § 410.39 is added to read as follows:

§ 410.39 Limitations on coverage of certain services furnished to hospital outpatients.

(a) Except as provided in paragraph (c) of this section, Medicare Part B does not pay for any item or service that is furnished to a hospital outpatient (as defined in § 410.2) during an encounter (as defined in § 410.2) by an entity other than the hospital unless the hospital has an arrangement (as defined in § 409.3 of this chapter) with that entity to furnish that particular service to its patients.

(b) As used in paragraph (a) of this section, the term ''hospital'' includes a CAH.

(c) The limitations stated in paragraphs (a) and (b) of this section do not apply to the following services:

(1) Physician services that meet the requirements of § 415.102(a) of this chapter for payment on a fee schedule basis.

(2) Physician assistant services, as defined in section 1861(s)(2)(K)(i) of the Act.

(3) Nurse practitioner and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

(4) Certified nurse mid-wife services, as defined in section 1861(gg) of the Act.

(5) Qualified psychologist services, as defined in section 1861(ii) of the Act.

(6) Services of an anesthetist, as defined in § 410.69.

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

C. Part 411 is amended as set forth below:

1. The authority citation for part 411 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395(hh)).

Subpart A—General Exclusions and Exclusion of Particular Services

2. In § 411.15, the introductory text is republished; the section heading to paragraph (m) is revised; paragraph (m)(1) is revised; the introductory text to paragraph (m)(2) is republished; paragraphs (m)(2)(iii), (m)(2)(iv), and (m)(2)(v) are redesignated as paragraphs (m)(2)(iv), (m)(2)(v), and (m)(2)(vi), respectively; and new paragraphs (m)(2)(iii) and (m)(3) are added to read as follows:

§ 411.15 Particular services excluded from coverage.

The following services are excluded from coverage.

* * * * *

(m) *Services to hospital patients*—(1) *Basic rule.* Except as provided in paragraph (m)(2) of this section, any service furnished to an inpatient of a hospital or to a hospital outpatient (as defined in § 410.2 of this chapter) during an encounter (as defined in § 410.2 of this chapter) by an entity other than the hospital, unless the hospital has an arrangement (as defined in § 409.3 of this chapter) with that entity to furnish that particular service to the hospital's patients. (As used in this paragraph (m)(1), the term ''hospital'' includes a CAH.)

(2) *Exceptions.* The following services are not excluded from coverage:

* * * * *

(iii) Nurse practitioner and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

* * * * *

(3) *Scope of exclusion.* Services subject to exclusion under the provisions of this paragraph (m) include, but are not limited to, clinical laboratory services; pacemakers and other prostheses and prosthetic devices (other than dental) that replace all or part of an internal body organ (for example, intraocular lenses); artificial limbs, knees, and hips; equipment and supplies covered under the prosthetic device benefits; and services incident to a physician service.

* * * * *

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

D. Part 412 is amended as set forth below:

1. The authority citation for part 412 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395(hh)).

Subpart C—Conditions for Payment Under the Prospective Payment Systems for Inpatient Operating Costs and Inpatient Capital-Related Costs

2. In § 412.50, paragraphs (a) and (b) are revised to read as follows:

§ 412.50 Furnishing of inpatient hospital services directly or under arrangements.

(a) The applicable payments made under the prospective payment systems, as described in subparts H and M of this part, are payment in full for all inpatient hospital services, as defined in § 409.10

of this chapter. Inpatient hospital services do not include the following types of services:

(1) Physician services that meet the requirements of § 415.102(a) of this chapter for payment on a fee schedule basis.

(2) Physician assistant services, as defined in section 1861(s)(2)(K)(i) of the Act.

(3) Nurse practitioner and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

(4) Certified nurse mid-wife services, as defined in section 1861(gg) of the Act.

(5) Qualified psychologist services, as defined in section 1861(ii) of the Act.

(6) Services of an anesthetist, as defined in § 410.69 of this chapter.

(b) HCFA does not pay any provider or supplier other than the hospital for services furnished to a beneficiary who is an inpatient, except for the services described in paragraphs (a)(1) through (a)(6) of this section.

* * * * *

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; OPTIONAL PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

E. Part 413 is amended as set forth below:

1. The authority citation for part 413 continues to read as follows:

Authority: Secs. 1102, 1861(v)(1)(A), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395x(v)(1)(A), and 1395hh).

Subpart A—Introduction and General Rules

§ 413.1 [Amended]

2. In § 413.1, paragraph (a)(2)(viii) is removed.

Subpart B—Accounting Records and Reports

3. In § 413.24, the heading to paragraph (d) is published, and a new paragraph (d)(6) is added to read as follows:

§ 413.24 Adequate cost data and cost finding.

* * * * *

(d) *Cost finding methods.* * * *

(6) *Management contracts.* (i) If the main provider purchases services for a department of the provider or a provider-based entity through a management contract or otherwise directly assigns costs to the department or entity, the like costs of the main provider must be carved out to ensure that they are not allocated to the department of the provider or provider-based entity. However, if the like costs of the main provider cannot be separately identified, the costs of the services purchased through a management contract must be included in the main provider's administrative and general costs and allocated among the provider's overall statistics.

(ii) Costs of free-standing entities may not be shown in the provider's trial balance for purposes of stepping down overhead costs to such entities. The provider must develop detailed work papers showing the exact cost of the services (including overhead) provided to or by the free-standing entity and show those carved out costs as non-reimbursable cost centers in the provider's trial balance.

* * * * *

Subpart E—Payments to Providers

4. A new § 413.65 is added to read as follows:

§ 413.65 Requirements for a determination that a facility or an organization is a department of a provider or a provider-based entity.

(a) *Definitions.* In this subpart E, unless the context indicates otherwise—

Department of a provider means a facility or organization or a physician office that is either created by, or acquired by, a main provider for the purpose of furnishing health care services under the name, ownership, and financial and administrative control of the main provider, in accordance with the provisions of this section. A department of a provider may not be licensed to provide health care services in its own right, and Medicare conditions of participation do not apply to a department as an independent entity. For purposes of this part, the term ''department of a provider'' does not include an RHC or an FQHC.

Free-standing facility means an entity that furnishes health care services to Medicare beneficiaries and that is not integrated with any other entity as a main provider, a department of a provider, or a provider-based entity.

Main provider means a provider that either creates, or acquires ownership of, another entity to deliver additional health care services under its name, ownership, and financial and administrative control.

Provider-based entity means a provider of health care services, or an RHC or an FQHC as defined in § 405.2401(b) of this chapter, that is either created by, or acquired by, a main provider for the purpose of furnishing health care services under the name, ownership, and administrative and financial control of the main provider, in accordance with the provisions of this section.

Provider-based status means the relationship between a main provider and a provider-based entity or a department of a provider, that complies with the provisions of this section.

(b) *Responsibility for obtaining provider-based determinations.* (1) A facility or organization is not entitled to be treated as provider-based simply because it or the main provider believe it is provider-based.

(2) A provider or a facility or organization must contact HCFA and the facility or organization must be determined by HCFA to be provider-based before the main provider begins billing for services of the facility or organization as if they were furnished by a department of the provider or provider-based entity, or before it includes costs of those services on its cost report.

(3) A facility that is not located on the campus of a hospital and is used as a site of physician services of the kind ordinarily furnished in physician offices will be presumed to be a free-standing facility, unless it is determined by HCFA to have provider-based status.

(c) *Reporting.* (1) A main provider that acquires a facility or organization for which it wishes to claim provider-based status, including any physician offices that a hospital wishes to operate as a hospital outpatient department or clinic, must report its acquisition of the facility or organization to HCFA and must furnish all information needed for a determination as to whether the facility or organization meets the requirements in paragraph (d) of this section for provider-based status.

(2) A main provider that has had one or more facilities or organizations considered provider-based also must report to HCFA any material change in the relationship between it and any provider-based facility or organization, such as a change in ownership of the facility or organization or entry into a new or different management contract that could affect the provider-based status of the facility or organization.

(d) *Requirements.* An entity must meet the following requirements to be determined by HCFA to be a provider-based entity or a department of a provider:

(1) *Licensure.* The department of the provider and the main provider are operated under the same license, except in areas where the State requires a separate license for the department of

the provider. If a State health facilities' cost review commission or other agency that has authority to regulate the rates charged by hospitals or other providers in a State finds that a particular facility or organization is not part of a provider, HCFA will determine that the facility or organization does not have provider-based status.

(2) *Operation under the ownership and control of the main provider.* The facility or organization seeking provider-based status is operated under the ownership and control of the main provider, as evidenced by the following:

(i) The facility or organization is 100 percent owned by the provider.

(ii) The main provider and the facility or organization seeking status as a department of the provider have the same governing body.

(iii) The facility or organization is operated under the same organizational documents as the main provider. For example, the facility or organization seeking provider-based status must be subject to common bylaws and operating decisions of the governing body of the provider where it is based.

(iv) The main provider has final responsibility for administrative decisions, final approval for contracts with outside parties, final approval for personnel actions, final responsibility for personnel policies (such as fringe benefits/code of conduct), and final approval for medical staff appointments in the facility or organization.

(3) *Administration and supervision.* The reporting relationship between the facility or organization seeking provider-based status and the main provider must have the same frequency, intensity, and level of accountability that exists in the relationship between the main provider and one of its departments, as evidenced by compliance with all of the following requirements:

(i) The facility or organization is under the direct supervision of the provider where it is located.

(ii) The facility or organization is operated under the same monitoring and oversight by the provider as any other department of the provider, and is operated just as any other department of the provider with regard to supervision and accountability. The facility or organization director or individual responsible for daily operations at the entity—

(A) Maintains a day-to-day reporting relationship with a manager at the main provider; and

(B) Is accountable to the governing body of the main provider, in the same manner as any department head of the provider.

(iii) The following administrative functions of the facility or organization are integrated with those of the provider where the facility or organization is based: billing services, records, human resources, payroll, employee benefit package, salary structure, and purchasing services. Either the same employees or group of employees handle these administrative functions for the facility or organization and the main provider, or the administrative functions for both the facility or organization and the entity are—

(A) Contracted out under the same contract agreement; or

(B) Handled under different contract agreements, with the contract of the facility or organization being managed by the main provider's billing department.

(4) *Clinical services.* The clinical services of the facility or organization seeking provider-based status and the main provider are integrated as evidenced by the following:

(i) Professional staff of the facility or organization have clinical privileges at the main provider.

(ii) The main provider maintains the same monitoring and oversight of the facility or organization as it does for any other department of the provider.

(iii) The medical director of the facility or organization seeking provider-based status maintains a day-to-day reporting relationship with the Chief Medical Officer or other similar official of the main provider, and is under the same type of supervision and accountability as any other director, medical or otherwise, of the main provider.

(iv) Medical staff committees or other professional committees at the main provider are responsible for medical activities in the facility or organization including quality assurance, utilization review, and the coordination and integration of services, to the extent practicable, between the facility or organization seeking provider-based status and the main provider.

(v) Medical records for patients treated in the facility or organization are integrated into a unified retrieval system (or cross reference) of the main provider.

(vi) Inpatient and outpatient services of the facility or organization and the main provider are integrated, and patients treated at the facility or organization who require further care have full access to all services of the main provider and are referred where appropriate to the corresponding inpatient or outpatient department or service of the main provider.

(5) *Financial integration.* The financial operations of the facility or organization are fully integrated within the financial system of the main provider, as evidenced by shared income and expenses between the main provider and the facility or organization. The costs of the facility or organization are reported in a cost center of the provider, and the financial status of the facility or organization is incorporated and readily identified in the main provider's trial balance.

(6) *Public awareness.* The facility or organization seeking status as a department of a provider is held out to the public and other payers as part of the main provider. When patients enter the provider-based facility or organization, they are aware that they are entering the main provider and are billed accordingly.

(7) *Location in immediate vicinity.* The facility or organization and the main provider are located on the same campus, except where the following requirements are met:

(i) The facility or organization demonstrates a high level of integration with the main provider by showing that it meets all of the other provider-based criteria, and demonstrates that it serves the same patient population as the main provider, either by submitting records such as common patient lists and/or demographic data showing that a high percentage of patients of both the main provider and the applicant entity come from the same geographic area, or by submitting data substantiating that the patients served by the entity also receive services from the main provider (for example, the patients of an RHC receive inpatient hospital services from the main provider).

(ii) A facility or organization is not considered to be in the ''immediate vicinity'' of the main provider if the facility or organization and the main provider are located in different States.

(e) *Provider-based status not applicable to joint ventures.* A facility or organization cannot be considered provider-based if the entity is owned by two or more providers engaged in a joint venture. For example, where a hospital has jointly purchased or jointly created free-standing facilities under joint venture arrangements, neither party to the joint venture arrangement can claim the free-standing facility as a provider-based entity.

(f) *Management contracts.* Facilities and organizations operated under management contracts are considered provider-based if all of the following criteria are met:

(1) The staff of the facility or organization are employed by the

provider or by another organization other than the management company.

(2) The administrative functions of the facility or organization are integrated with those of the main provider, as determined under criteria in paragraph (b)(3)(iii) of this section.

(3) The main provider has significant day-to-day control over the operations of the facility or organization as determined under criteria in paragraph (b)(3)(ii) of this section.

(4) The management contract is held by the main provider itself, not by a parent organization that has control over both the main provider and the facility or organization.

(g) *Obligations of hospital outpatient departments and hospital-based entities.* (1) Hospital outpatient departments located either on or off the main premises of the hospital must comply with the anti-dumping rules in §§ 489.20(l), (m), (q), and (r) and 489.24 of this chapter. If any individual comes to any hospital-based entity (including an RHC) located on the main hospital campus, and a request is made on the individual's behalf for examination or treatment of a medical condition, as described in § 489.24, the hospital must comply with the anti-dumping rules in § 489.24.

(2) Physician services furnished in hospital outpatient departments or hospital-based entities (other than RHCs) must be billed with the correct site-of-service indicator, so that applicable site-of-service reductions to physician and practitioner payment amounts can be applied.

(3) Hospital outpatient departments must comply with all the terms of the hospital's provider agreement.

(4) Physicians who work in hospital outpatient departments or hospital-based entities are obligated to comply with the non-discrimination provisions in § 489.10(b) of this chapter.

(5) Hospital outpatient departments (other than RHCs) must hold themselves out to other payers as outpatient departments of that hospital, and must treat all patients, for billing purposes, as hospital outpatients. The department must not treat some patients as hospital outpatients and others as physician office patients.

(6) In the case of a patient admitted to the hospital as an inpatient after receiving treatment in the hospital outpatient department or hospital-based entity, payments for services in the hospital outpatient department or hospital-based entity are subject to the payment window provisions applicable to PPS hospitals and to hospitals and units excluded from PPS set forth at § 412.2(c)(5) of this chapter and at § 413.40(c)(2), respectively.

(7) When a Medicare beneficiary is treated in a hospital outpatient department or hospital-based entity (other than an RHC), the hospital has a duty to notify the beneficiary, prior to the delivery of services, of the beneficiary's potential financial liability (that is, a coinsurance liability for an outpatient visit to the hospital as well as for the physician service).

(8) Hospital outpatient departments must meet applicable hospital health and safety rules for Medicare-participating hospitals in part 482 of this chapter.

(9) A facility or organization may not qualify for provider-based status if all services furnished at the facility are furnished under arrangement.

(h) *Inappropriate treatment of a facility or organization as provider-based.* If HCFA learns of a provider treating a facility or organization as provider-based without notifying HCFA to obtain a determination of provider-based status, HCFA reconsiders all payments to that provider for all cost reporting periods subject to re-opening in accordance with §§ 405.1885 and 405.1889 of this chapter. HCFA then investigates and determines whether the requirements in paragraph (d) of this section were met. If the facility or organization did not qualify for a provider-based determination, HCFA recovers the difference between the amount of payments that actually were made and the amount of payments that should have been made in the absence of a determination of provider-based status, except that recovery will not be made for any period prior to [insert the effective date of final rule] if during all of that period the management of the entity made a good faith effort to operate it as a provider-based facility or organization, as described in paragraph (i)(2) of this section.

(i) *Inappropriate billing.* (1) If HCFA determines that a provider has been inappropriately billing Medicare for services furnished in a physician office or other facility or organization as if they had been furnished in a hospital outpatient department or other department of a provider or in a provider-based entity, HCFA stops all payments to the provider for outpatient services until the provider can demonstrate which payments are proper. If overpayments have been made, HCFA recovers the difference between the amount of payments that actually were made and the amount of the payments that should have been made in the absence of the determination of provider-based status. However, past payments attributable to treatment as a department of a provider or a provider-based entity for any period prior to [insert effective date of final rule] are not recovered if during all of that period the management of a facility or an organization made a good faith effort to operate it as a department of a provider or a provider-based entity, as described in paragraph (i)(2) of this section, prior to [insert effective date of final rule].

(2) HCFA determines that the management of a facility has made a good faith effort to operate it as a provider-based entity if—

(i) The requirements regarding licensure and public awareness in paragraphs (d)(1) and (d)(6) of this section are met;

(ii) All facility services were billed as if they had been furnished by a department of a provider or a provider-based entity of the main provider; and

(iii) All professional services of physicians and other practitioners were billed with the correct site-of-service indicator, as described in paragraph (g)(7) of this section.

(j) *Correction of errors.* HCFA may review a past determination of provider-based status if it believes that the determination may be inappropriate, based on the provisions of this section. If HCFA determines that a previous determination was in error, and the entity should not be considered provider-based, HCFA notifies the main provider. Treatment of the facility or organization as provider-based ceases with the first day of the next cost report period following notification of the redetermination.

Subpart F—Specific Categories of Costs

5. In § 413.118, the heading to paragraph (d) is republished, and a new paragraph (d)(5) is added to read as follows:

§ 413.118 Payment for facility services related to covered ASC surgical procedures performed in hospitals on an outpatient basis.

* * * * *

(d) *Blended payment amount.* * * *

(5) For portions of cost reporting periods beginning on or after October 1, 1997, for purposes of calculating the blended payment amount under paragraph (d)(4) of this section, the ASC payment amount is the sum of the standard overhead amounts reduced by deductibles and coinsurance as defined in section 1866(a)(2)(ii) of the Act.

* * * * *

6. In § 413.122, the heading to paragraph (b) is republished, a new

paragraph (b)(5) is added, the heading to paragraph (c) is republished, and a new paragraph (c)(4) is added to read as follows:

413.122 Payment for hospital outpatient radiology services and other diagnostic procedures.

* * * * *

(b) *Payment for hospital outpatient radiology services.* * * *

(5) For hospital outpatient radiology services furnished on or after October 1, 1997, the blended payment amount is equal to the sum of—

(i) 42 percent of the hospital-specific amount; and

(ii) 58 percent of the fee schedule amount calculated as 62 percent of the sum of the fee schedule amounts payable for the same services when furnished by participating physicians in their offices in the same locality, less deductible and coinsurance as defined in section 1866(a)(2)(A)(ii) of the Act.

(c) *Payment for other diagnostic procedures.* * * *

(4) For other diagnostic services furnished on or after October 1, 1997, the blended payment amount is equal to the sum of—

(i) 50 percent of the hospital-specific amount; and

(ii) 50 percent of the fee schedule amount calculated as 42 percent of the sum of the fee schedule amounts payable for the same services when furnished by participating physicians in their offices in the same locality, less deductible and coinsurance as defined in section 1866(a)(2)(A)(ii) of the Act.

7. In § 413.124, paragraph (a) is revised to read as follows:

§ 413.124 Reduction to hospital outpatient operating costs.

(a) Except for sole community hospitals, as defined in § 412.92 of this chapter, and critical access hospitals, the reasonable costs of outpatient hospital services (other than capital-related costs of such services) are reduced by 5.8 percent for services furnished during portions of cost reporting periods occurring on or after October 1, 1990 and before January 1, 2000.

* * * * *

Subpart G—Capital-Related Costs

8. In § 413.130, the heading to paragraph (j) and the introductory text to paragraph (j)(1) are republished, and paragraph (j)(1)(ii) is revised to read as follows:

§ 413.130 Introduction to capital-related costs.

* * * * *

(j) *Reduction to capital-related costs.* (1) Except for sole community hospitals and critical access hospitals, the amount of capital-related costs of all hospital outpatient services is reduced by—

* * * * *

(ii) 10 percent for portions of cost reporting periods occurring on or after October 1, 1991 through December 31, 1999 and before January 1, 2000.

* * * * *

F. A new part 419, consisting of §§ 419.1, 419.2, 419.20, 419.21, 419.22, 419.30, 419.31, 419.32, 419.40, 419.41, 419.42, 419.43, 419.44, 419.50, 419.51, and 419.60, is added to read as follows:

PART 419—PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

Subpart A—General Provisions

Sec.
419.1 Scope of part.
419.2 Basis of payment.

Subpart B—Services Subject to and Excluded From the Hospital Outpatient Prospective Payment System

419.20 Hospitals subject to the hospital outpatient prospective payment system.
419.21 Hospital outpatient services subject to the outpatient prospective payment system.
419.22 Hospital outpatient services excluded from payment under the hospital outpatient prospective payment system.

Subpart C—Basic Methodology for Determining Prospective Payment Rates for Hospital Outpatient Services

419.30 Base expenditure target for calendar year 1999.
419.31 Ambulatory Payment Classification (APC) system and payment weights.
419.32 Calculation of prospective payment rates for hospital outpatient services.

Subpart D—Payments to Hospitals

419.40 Payment concepts.
419.41 Calculation of national beneficiary copayment amounts and national Medicare program payment amounts.
419.42 Hospital election to reduce copayment.
419.43 Adjustments to national program payment and beneficiary copayment amounts.
419.44 Payment reductions for surgical procedures.

Subpart E—Updates

419.50 Revisions to groups, weights, and other adjustments.
419.51 Volume control measures for services furnished in CY 2000.

Subpart F—Limitations on Review

419.60 Limitations on administrative and judicial review.

Authority: Secs. 1102, 1833(t), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395l(t), and 1395(hh)).

PART 419—PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

Subpart A—General Provisions

§ 419.1 Scope of part.

(a) *Purpose.* This part implements section 1833(t) of the Act by establishing a prospective payment system for services furnished by hospital outpatient departments to Medicare beneficiaries who are registered on hospital records as outpatients, effective for services furnished on or after the implementation date.

(b) *Summary of content.* This subpart describes the basis of payment for outpatient hospital services under the prospective payment system. Subpart B sets forth the categories of hospitals and services that are subject to the outpatient hospital prospective payment system and those categories of hospitals and services that are excluded from the outpatient hospital prospective payment system. Subpart C sets forth requirements and the basic methodology by which prospective payment rates for hospital outpatient services are determined. Subpart D describes Medicare payment amounts, beneficiary copayment amounts, and methods of payment to hospitals under the hospital outpatient prospective payment system. Subpart E describes how the hospital outpatient prospective payment system may be revised to take into account changes in medical practice and technology, the addition or deletion of services, new cost data, and other relevant information and factors.

§ 419.2 Basis of payment.

(a) *Unit of payment.* Under the hospital outpatient prospective payment system, hospitals are paid a predetermined amount for designated services, which are identified by codes established under the Health Care Financing Administration Common Procedure Coding System (HCPCS), furnished to Medicare beneficiaries. The prospective payment rate for each service or procedure for which payment is allowed under the hospital outpatient prospective payment system is determined according to the methodology described in subpart C of this part. The manner in which the Medicare payment amount and the beneficiary copayment amount for each service or procedure are determined is described in subpart D of this part.

(b) *Costs included in determination of hospital outpatient department payment rates.* The prospective payment system establishes a national payment rate,

standardized for geographic wage differences, for operating and capital-related costs that are directly related and integral to performing a procedure or furnishing a service on an outpatient basis, including, but not limited to—

(1) Use of an operating suite, procedure room, or treatment room;

(2) Use of recovery room;

(3) Use of an observation bed;

(4) Anesthesia, drugs, biologicals, other pharmaceuticals, and blood; medical and surgical supplies and equipment; surgical dressings; splints, casts, and other devices used for reduction of fractures and dislocations;

(5) Supplies and equipment for administering and monitoring anesthesia or sedation;

(6) Intra-ocular lenses (IOLs);

(7) Incidental services such as venipuncture;

(8) Capital-related costs.

(c) *Costs excluded from determination of hospital outpatient prospective payment rates.* The following costs are excluded from the hospital outpatient prospective payment rates:

(1) Medical education costs for approved nursing and allied health education programs.

(2) Costs for services listed in § 419.22.

Subpart B—Services Subject to and Excluded From the Hospital Outpatient Prospective Payment System

§ 419.20 Hospitals subject to the hospital outpatient prospective payment system.

(a) *Applicability.* The hospital outpatient prospective payment system is applicable to any hospital participating in the Medicare program, except those specified in paragraph (b) of this section, for services furnished on or after the implementation date.

(b) *Hospitals excluded from the outpatient prospective payment system.* (1) Those services furnished by Maryland hospitals that are paid under a cost containment waiver in accordance with section 1814(b)(3) of the Act are excluded from the hospital outpatient prospective payment system.

(2) Critical access hospitals (CAHs) are excluded from the hospital outpatient prospective payment system.

§ 419.21 Hospital outpatient services subject to the outpatient prospective payment system.

Beginning on the implementation date, except for services described in § 419.22, payment is made under the hospital outpatient prospective payment system for—

(a) Medicare Part B services furnished to hospital outpatients designated by HCFA under this part that are not otherwise excluded under § 419.22;

(b) Services that are covered under Medicare Part B when furnished to hospital inpatients who are either not entitled to benefits under Part A or who have exhausted their Part A benefits, but are entitled to benefits under Part B of the program;

(c) Partial hospitalization services furnished by community mental health centers (CMHCs);

(d) The following medical and other health services furnished by a comprehensive outpatient rehabilitation facility (CORF) when they fall outside the definition of CORF services at section 1861(cc)(1) of the Act; or by a home health agency (HHA) to patients who are not under an HHA plan or treatment; or, by a hospice program furnishing services to patients outside the hospice benefit:

(1) Antigens.

(2) Splints and casts.

(3) Pneumococcal vaccine, influenza vaccine, hepatitis B vaccine.

§ 419.22 Hospital outpatient services excluded from payment under the hospital outpatient prospective payment system.

The following services are not paid for under the hospital outpatient prospective payment system:

(a) Physician services.

(b) Nurse practitioner services.

(c) Physician assistant services.

(d) Certified nurse-midwife services.

(e) Services of qualified psychologists.

(f) Services of an anesthetist as defined in § 410.69 of this chapter.

(g) Clinical social worker services as defined in section 1861(hh)(2) of the Act.

(h) Rehabilitation services described in section 1833(a)(8) of the Act.

(i) Ambulance services.

(j) Prosthetics and prosthetic supplies, prosthetic devices, prosthetic implants (except IOLs), and orthotic devices.

(k) Durable medical equipment supplied by the hospital for the patient to take home.

(l) Clinical diagnostic laboratory services.

(m) Dialysis services furnished to ESRD patients.

(n) Services and procedures that are not safely furnished in an outpatient setting or that require inpatient care.

(o) Services specific to other sites such as nursing homes.

(p) Services furnished to persons who are inpatients of a SNF and furnished pursuant to the resident assessment or comprehensive care plan but that are covered under the SNF prospective payment system, furnished ''under arrangement,'' and billable only by the SNF.

(q) Services that are not covered by Medicare by statute.

(r) Services that are not reasonable or necessary for the diagnosis or treatment of an illness or disease.

Subpart C—Basic Methodology for Determining Prospective Payment Rates for Hospital Outpatient Services

§ 419.30 Base expenditure target for calendar year 1999.

(a) HCFA estimates the aggregate amount that would be payable for hospital outpatient services in calendar year 1999 by summing—

(1) The total amounts that would be payable from the Trust Fund for covered hospital outpatient services without regard to the outpatient prospective payment system described in this part; and

(2) The total amounts of copayments estimated to be paid by beneficiaries, under the prospective payment system described in this part, to hospitals for covered hospital outpatient services.

(b) The aggregate amount under paragraph (a) of this section is determined as though the deductible required under section 1833(b) of the Act did not apply.

§ 419.31 Ambulatory Payment Classification (APC) system and payment weights.

(a) *APC groups.* (1) HCFA classifies hospital outpatient services and procedures that are comparable clinically and similar in terms of resource use into APC groups.

(2) The payment rate determined for an APC group in accordance with § 419.32 and the copayment amount and program payment amount determined for an APC group in accordance with subpart D of this part apply to every individual service or procedure within the APC group.

(b) *APC weighting factors.* (1) Using hospital claims data from calendar year 1996 and data from the most recent available hospital cost reports, HCFA determines the median costs for the services and procedures within each APC group.

(2) HCFA assigns to each APC group an appropriate weighting factor to reflect the relative median costs for the services within the APC group compared to the median costs for the services in all APC groups.

(c) *Standardizing amounts.* (1) HCFA determines the portion of costs determined in paragraph (b)(1) of this section that is labor-related. This is known as the ''labor-related portion'' of hospital outpatient costs.

(2) HCFA standardizes the median costs determined in paragraph (b)(1) of

this section by adjusting for variations in hospital labor costs across geographic areas.

§ 419.32 Calculation of prospective payment rates for hospital outpatient services.

(a) *Conversion factor for 1999.* HCFA calculates a conversion factor in such a manner as to ensure that payment for hospital outpatient services furnished in 1999 would have equalled the base expenditure target calculated in § 419.30, taking APC group weights and estimated service volume into account.

(b) *Conversion factor for calendar years 2000, 2001, and 2002.* (1) Subject to paragraph (c)(2) of this section, the conversion factor for each of the calendar years 2000, 2001, and 2002 is equal to the conversion factor calculated under paragraph (a) of this section for the previous year adjusted by the hospital inpatient market basket percentage increase applicable under section 1886(b)(3)(B)(iii) of the Act for fiscal years 2000, 2001, and 2002, respectively, reduced by one percentage point.

(2) Beginning in calendar year 2000, HCFA may substitute for the hospital inpatient market basket percentage in paragraph (c)(1) of this section a market basket percentage increase that is determined and applied to hospital outpatient services in the same manner that the hospital inpatient market basket percentage increase is determined and applied to inpatient hospital services.

(c) *Payment rates.* The payment rate for services and procedures for which payment is made under the hospital outpatient prospective payment system is the product of the conversion factor calculated under paragraph (a) or paragraph (b) of this section and the relative weight determined under § 419.31(b).

Subpart D—Payments to Hospitals

§ 419.40 Payment concepts.

In addition to the payment rate described in § 419.32, for each APC group there is a predetermined beneficiary copayment amount as described in § 419.41(a). The Medicare payment for each APC is calculated by applying the program payment percentage as described in § 419.41(b).

(b) For purposes of this section—

Copayment percentage is calculated as the difference between the program payment percentage and 100 percent. The copayment percentage in any year is thus defined for each APC group as the *greater* of the following: the ratio of the APC group unadjusted copayment amount *to* the annual APC group payment rate, or 20 percent.

Program payment percentage is calculated as the *lower* of the following: the ratio of the APC group payment rate minus the APC group unadjusted copayment amount, *to* the APC group payment rate, *or* 80 percent.

Unadjusted copayment amount is calculated as 20 percent of the wage-adjusted national median of charges for services within an APC group furnished during 1996, updated to 1999 using an actuarial projection of charge increases for hospital outpatient department services during the period 1996 to 1999.

§ 419.41 Calculation of national beneficiary copayment amounts and national Medicare program payment amounts.

(a) *Calculation of the national beneficiary copayment amount.* To calculate the unadjusted copayment amount for each APC group, HCFA—

(1) Standardizes 1996 hospital charges for the services within each APC group to offset variations in hospital labor costs across geographic areas;

(2) Identifies the median of the wage-neutralized 1996 charges for each APC group; and,

(3) Determines the value equal to 20 percent of the wage-neutralized 1996 median charge for each APC group and multiplies that value by an actuarial projection of increases in charges for hospital outpatient department services during the period 1996 to 1999. The result is the unadjusted beneficiary copayment amount for the APC group.

(b) *Calculation of the program payment amount for each APC group.* (1) HCFA calculates annually the program payment percentage for every APC group on the basis of each group's unadjusted copayment amount and its payment rate after the payment rate is adjusted in accordance with § 419.32.

(2) The Medicare program payment amounts are calculated annually by multiplying the updated APC group payment rates by the program payment percentage.

(c) To determine payment amounts due for a service paid for under the hospital outpatient prospective payment system, HCFA makes the following calculations:

(1) Makes the wage index adjustment and any other adjustments that are appropriate in accordance with § 419.43.

(2) Subtracts the amount of the applicable Part B deductible provided under § 410.160 of this chapter.

(3) Multiplies the remainder by the program payment percentage for the group to determine the program payment amount.

(4) Subtracts the program payment amount from the amount determined in paragraph (c)(2) of this section to determine the copayment amount.

§ 419.42 Hospital election to reduce copayment.

(a) A hospital may elect to reduce copayments for any or all APC groups on a calendar year basis. A hospital may *not* elect to reduce copayment for some, but not all, services within the same group.

(b) A hospital must notify its fiscal intermediary of its election to reduce copayments no later than 90 days prior to the start of the calendar year.

(c) The hospital's election must be properly documented. It must specifically identify the APCs to which it applies and the copayment level (within the limits identified below) that the hospital has selected for each group.

(d) The election of reduced copayment must remain in effect unchanged during the year for which the election was made.

(e) The hospital may advertise and otherwise disseminate information concerning the reduced level(s) of copayment that it has elected.

(f) In electing reduced copayment, a hospital may elect a level that is less than that year's national copayment amount for the group, but not less than 20 percent of the APC payment rate as determined in § 419.32.

§ 419.43 Adjustments to national program payment and beneficiary copayment amounts.

(a) *General rule.* HCFA determines national prospective payment rates for hospital outpatient department services and determines a wage adjustment factor to adjust the portion of the APC payment and national beneficiary copayment amount attributable to labor-related costs for relative differences in labor and labor-related costs across geographic regions in a budget neutral manner.

(b) *Labor-related portion of payment and copayment rates for hospital outpatient services.* HCFA determines the portion of hospital outpatient costs attributable to labor and labor-related costs (known as the ''labor-related portion'' of hospital outpatient costs) in accordance with § 419.31(c)(1).

(c) *Wage index factor.* HCFA uses the hospital inpatient prospective payment system wage index established in accordance with section 1886(d)(3)(E) of the Act and part 412 of this chapter to make the adjustment referred to in paragraph (a) of this section.

(d) *Other adjustments.* Any other adjustments to payment amounts made by HCFA to ensure equitable payments are made in a budget neutral manner.

§ 419.44 Payment reductions for surgical procedures.

(a) *Multiple surgical procedures.* When more than one surgical procedure for which payment is made under the hospital outpatient prospective payment system is performed during a single surgical encounter, the Medicare program payment amount and the beneficiary copayment amount are based on—

(1) The full amounts for the procedure with the highest APC payment rate; and

(2) One half of the full program and beneficiary payment amounts for all other covered procedures.

(b) *Terminated procedures.* When a surgical procedure is terminated prior to completion due to extenuating circumstances or circumstances that threaten the well-being of the patient, the Medicare program payment amount and the beneficiary copayment amount are based on—

(1) The full amounts if the procedure is discontinued after the induction of anesthesia or after the procedure is started; and

(2) One-half of the full program and beneficiary payment amounts if the procedure is discontinued after the patient is prepared for surgery and taken to the room where the procedure is to be performed, but before anesthesia is induced.

Subpart E—Updates

§ 419.50 Revisions to groups, weights, and other adjustments.

(a) HCFA periodically reviews and updates groups, relative payment weights, and the wage and other adjustments to take into account changes in medical practice, changes in technology, the addition of new services, new cost data, and other relevant information and factors.

(1) *Changes in the APC system.* HCFA may make a change in the group composition of the APC system or recalibrate any APC weight, as needed, but not more frequently than once a year. HCFA makes these changes based on evidence that a reassignment would improve the consistency of the group(s) either clinically or with respect to resource consumption.

(2) *New services.* HCFA assigns a new service to the APC group that is most similar clinically and with respect to resource consumption.

(3) *Budget neutrality.* HCFA adjusts the conversion factor so that any adjustments determined under paragraphs (a)(1) through (a)(3) of this section do not increase or decrease the amount of expenditures that would have been made under this section if the adjustments had not been made.

(b) *Annual update to conversion factor.* HCFA updates the conversion factor annually as specified in § 419.32.

§ 419.51 Volume control measures for services furnished in CY 2000.

HCFA uses the target amount specified under section 1833(t)(3)(A) of the Act as an expenditure target for services furnished in CY 1999. HCFA updates the target amount to CY 2000 based on the adjustment to the conversion factor in § 419.32(b), estimated changes in the volume and intensity of hospital outpatient services, and estimated changes in beneficiary enrollment. HCFA compares the CY 2000 target to an estimate of CY 2000 actual payments to hospitals. If unnecessary volume increases cause payments to exceed the target, HCFA determines the percentage by which the target is exceeded, and adjusts the CY 2002 update to the conversion factor by the same percentage.

Subpart F—Limitations on Review

§ 419.60 Limitations on administrative and judicial review.

There can be no administrative or judicial review under sections 1869 and 1878 of the Act, or otherwise of—

(a) The development of the APC system, including—

(1) Establishment of the groups and relative payment weights;

(2) Wage adjustment factors;

(3) Other adjustments; and

(4) Methods for controlling unnecessary increases in volume.

(b) The calculation of base amounts described in section 1833(t)(3) of the Act;

(c) Periodic adjustments described in section 1833(t)(6) of the Act; and

(d) The establishment of a separate conversion factor for hospitals described in section 1886(d)(1)(B)(v) of the Act.

PART 489—PROVIDER AGREEMENTS AND SUPPLIER APPROVAL

G. Part 489 is amended as set forth below:

1. The authority citation to part 489 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart B—Essentials of Provider Agreements

2. In § 489.20, the introductory text to the section is republished; the introductory text to paragraph (d) is revised; paragraphs (d)(3), (d)(4), and (d)(5) are redesignated as paragraphs (d)(4), (d)(5), and (d)(6), respectively; and a new paragraph (d)(3) is added to read as follows:

§ 489.20 Basic commitments.

The provider agrees to the following:

* * * * *

(d) In the case of a hospital or a CAH that furnishes services to Medicare beneficiaries, either to furnish directly or to make arrangements (as defined in § 409.3 of this chapter) for all Medicare-covered services to inpatients and outpatients of a hospital or a CAH except the following:

* * * * *

(3) Nurse practitioner and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

* * * * *

3. In § 489.24(b), the definition for ''Comes to the emergency department'' is revised to read as follows:

§ 489.24 Special responsibilities of Medicare hospitals in emergency cases.

* * * * *

(b) * * *

Comes to the emergency department means, with respect to an individual requesting examination or treatment, that the individual is on the hospital property. For purposes of this section, ''property'' means the entire main hospital campus, including the parking lot, sidewalk, and driveway, as well as any facility or organization that is located off the main hospital campus but has been determined under § 416.35 of this chapter to be a department of the hospital. Property also includes ambulances owned and operated by the hospital, even if the ambulance is not on hospital grounds. An individual in a nonhospital-owned ambulance on hospital property is considered to have come to the hospital's emergency department. An individual in a nonhospital-owned ambulance off hospital property is not considered to have come to the hospital's emergency department, even if a member of the ambulance staff contacts the hospital by telephone or telemetry communications and informs the hospital that they want to transport the individual to the hospital for examination and treatment. In such situations, the hospital may deny access if it is in ''diversionary status,'' that is, it does not have the staff or facilities to accept any additional emergency patients. If, however, the ambulance staff disregards the hospital's instructions and transports the individual on to hospital property, the individual is considered to have come to the emergency department.

* * * * *

PART 498—APPEALS PROCEDURES FOR DETERMINATIONS THAT AFFECT PARTICIPATION IN THE MEDICARE PROGRAM AND FOR DETERMINATIONS THAT AFFECT THE PARTICIPATION OF ICFs/MR AND CERTAIN NFs IN THE MEDICAID PROGRAM

H. Part 498 is amended as set forth below:

1. The authority citation for part 498 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395(hh).

2. In § 498.2, the introductory text is republished, and the definition of ''Provider'' is revised to read as follows:

§ 498.2 Definitions.

As used in this part —

* * * * *

Provider means a hospital, critical access hospital (CAH), skilled nursing facility (SNF), comprehensive outpatient rehabilitation facility (CORF), home health agency (HHA), or hospice, that has in effect an agreement to participate in Medicare, that has in effect an agreement to participate in Medicaid, or a clinic, rehabilitation agency, or public health agency that has a similar agreement but only to furnish outpatient physical therapy or outpatient speech pathology services, and *prospective provider* means any of the listed entities that seeks to participate in Medicare as a provider or to have any facility or organization determined to be a department of the provider or provider-based entity under § 412.65 of this chapter.

* * * * *

3. In § 498.3, the introductory text to paragraph (b) is republished; paragraphs (b)(2) through (b)(14) are redesignated as paragraphs (b)(3) through (b)(15), respectively; and a new paragraph (b)(2) is added to read as follows:

§ 498.3 Scope and applicability.

* * * * *

(b) *Initial determinations by HCFA.* HCFA makes initial determinations with respect to the following matters:

* * * * *

(2) Whether a prospective department of a provider or provider-based entity qualifies as a department of a provider or provider-based entity under § 413.65 of this chapter.

* * * * *

PART 1003—CIVIL MONEY PENALTIES, ASSESSMENTS AND EXCLUSIONS

I. Part 1003 is amended as set forth below:

1. The authority citation for part 1003 is revised to read as follows:

Authority: 42 U.S.C. 1302, 1320–7, 1320a-7a, 1320b-10, 1395u(j), 1395u(k), 1395cc(g), 1395dd(d)(1), 1395mm, 1395nn(g), 1395ss(d), 1396b(m), 11131(c) and 11137(b)(2).

2. Section 1003.100 is amended by revising paragraph (a) to read as follows:

§ 1003.100 Basis and purpose.

(a) *Basis.* This part implements sections 1102, 1128(c), 1128A, 1140, 1842(j), 1842(k), 1866(g), 1876(i)(6), 1877(g), 1882(d) and 1903(m)(5) of the Social Security Act, and sections 421(c) and 427(b)(2) of Pub. L. 99–660 (42 U.S.C. 1302, 1320a–7, 1320a–7a, 1320b–10, 1395u(j), 1395u(k), 1395cc(g), 1395mm(i)(6), 1395nn(g), 1395ss(d), 1396d(m)(5), 11131(c) and 11137(b)(2)).

* * * * *

3. Section 1003.102 is amended by republishing the introductory text to paragraph (b), by reserving paragraphs (b)(11) through (b)(13), and by adding a new paragraph (b)(14) to read as follows:

§ 1003.102 Basis for civil money penalties and assessments.

* * * * *

(b) The OIG may impose a penalty, and where authorized, an assessment against any person (including an insurance company in the case of paragraphs (b)(5) and (b)(6) of this section) whom it determines in accordance with this part—

* * * * *

(11) [Reserved]

(12) [Reserved]

(13) [Reserved]

(14) Has knowingly and willfully presented, or caused to be presented, a bill or request for payment for an item or service furnished to a hospital patient for which payment may be made under the Medicare or another Federal health care program, if that bill or request is inconsistent with an arrangement under section 1866(a)(1)(H) of the Act, or violates the requirements for such an arrangement.

* * * * *

4. Section 1003.103 is amended by revising paragraph (a) to read as follows:

§ 1003.103 Amount of penalty.

(a) Except as provided in paragraphs (b) through (f) of this section, the OIG may impose a penalty of not more than $10,000 for each item or service that is subject to a determination under § 1003.102.

* * * * *

5. Section 1003.105 is amended by revising paragraph (a)(1)(i) to read as follows:

§ 1003.105 Exclusion from participation in Medicare and State health care programs.

(a)(1) * * *

(i) Any person who is subject to a penalty or assessment under § 1003.102(a), (b)(1) through (b)(4), or (b)(14).

* * * * *

(Catalog of Federal Domestic Assistance 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: June 29, 1998.

Nancy-Ann Min DeParle,

Administrator, Health Care Financing Administration.

Dated: June 29, 1998.

June G. Brown,

Inspector General, Department of Health and Human Services.

Approved: August 15, 1998.

Donna E. Shalala,

Secretary.

Note: The following addenda will not appear in the Code of Federal Regulations.

ADDENDUM A.—LIST OF PROPOSED HOSPITAL OUTPATIENT AMBULATORY PAYMENT CLASSES WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COINSURANCE AMOUNTS

APC [1] [2]	Group title	Status indicator	Relative weight	Payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
020	Partial Hospitalization per diem	S	4.11	$208.01	$46.78	$41.60
031	Dental procedures	S	1.34	$67.90	$13.58	$13.58
061	Level I Chemotherapeutic agents	X	1.04	$52.70	$36.61	$10.54
062	Level II Chemotherapeutic agents	X	1.69	$85.63	$36.61	$17.13

[1] *APCs preceded by an asterisk have anomalous weights. Refer to the Preamble for discussion.

[2] +APCs preceded by a plus sign (+) indicate the median cost of all claims in combined levels of the MDC was calculated; one rate is paid for multiple levels.

ADDENDUM A.—LIST OF PROPOSED HOSPITAL OUTPATIENT AMBULATORY PAYMENT CLASSES WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COINSURANCE AMOUNTS—Continued

APC[1 2]	Group title	Status indicator	Relative weight	Payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
063	Level III Chemotherapeutic agents	X	2.89	$146.43	$110.97	$29.29
064	Level IV Chemotherapeutic agents	X	4.17	$211.29	$140.12	$42.26
089	Neuropsychological Testing	X	2.54	$128.70	$37.29	$25.74
090	Monitoring psychiatric drugs	X	0.85	$43.07	$12.43	$8.61
091	Brief Individual Psychotherapy	S	1.09	$55.23	$14.01	$11.05
092	Extended Individual Psychotherapy	S	1.57	$79.55	$21.92	$15.91
093	Family Psychotherapy	S	1.54	$78.03	$20.11	$15.61
094	Group Psychotherapy	S	1.24	$62.83	$20.11	$12.57
121	Level I needle biopsy/aspiration	T	0.67	$33.95	$20.91	$6.79
122	Level II needle biopsy/aspiration	T	4.87	$246.76	$115.03	$49.35
131	Level I incision & drainage	T	1.94	$98.30	$36.61	$19.66
132	Level II incision & drainage	T	6.04	$306.04	$134.13	$61.21
137	Nail procedures	T	0.46	$23.31	$4.66	$4.66
141	Level I Destruction of lesion	T	0.59	$29.90	$9.49	$5.98
142	Level II Destruction of lesion	T	3.77	$191.02	$73.00	$38.20
151	Level I debridement/destruction	T	1.74	$88.16	$35.71	$17.63
152	Level II debridement/destruction	T	10.43	$528.48	$261.71	$105.70
161	Level I excision/biopsy	T	3.50	$177.34	$75.48	$35.47
162	Level II excision/biopsy	T	5.67	$287.30	$125.43	$57.46
163	Level III excision/biopsy	T	10.69	$541.66	$264.65	$108.33
181	Level I skin repair	T	2.19	$110.97	$43.84	$22.19
182	Level II skin repair	T	4.00	$202.68	$84.98	$40.54
183	Level III skin repair	T	11.17	$565.98	$286.46	$113.20
184	Level IV skin repair	T	15.17	$768.66	$396.40	$153.73
197	Incision/excision breast	T	12.13	$614.62	$310.75	$122.92
198	Breast reconstruction/mastectomy	T	19.17	$971.33	$530.20	$194.27
200	Arthrocentesis & Ligament/Tendon Injection	T	1.89	$95.77	$39.10	$19.15
207	Closed treatment fracture finger/toe/trunk	T	1.70	$86.14	$31.64	$17.23
209	Closed treatment fracture/dislocation/except finger/toe/trunk.	T	1.94	$98.30	$37.29	$19.66
210	Bone/joint manipulation under anesthesia	T	10.46	$530.00	$283.40	$106.00
216	Open/percutaneous treatment fracture or dislocation.	T	20.13	$1,019.98	$520.82	$204.00
217	Arthroplasty	T	20.48	$1,037.71	$526.81	$207.54
218	Arthroplasty with prosthesis	T	27.49	$1,392.90	$715.52	$278.58
*226	Maxillofacial prostheses	T	1.59	$80.56	$21.92	$16.11
231	Level I skull and facial bone procedures	T	12.02	$609.05	$299.90	$121.81
232	Level II skull and facial bone procedures	T	23.93	$1,212.52	$639.35	$242.50
251	Level I Musculoskeletal Procedures	T	14.26	$722.55	$366.12	$144.51
252	Level II Musculoskeletal Procedures	T	19.39	$982.48	$509.18	$196.50
253	Level III Musculoskeletal Procedures	T	26.33	$1,334.13	$699.24	$266.83
254	Level IV Musculoskeletal Procedures	T	34.37	$1,741.51	$937.11	$348.30
261	Level I Hand Musculoskeletal Procedures	T	10.54	$534.06	$261.48	$106.81
262	Level II Hand Musculoskeletal Procedures	T	18.35	$929.78	$480.82	$185.96
271	Level I Foot Musculoskeletal Procedures	T	14.41	$730.15	$368.38	$146.03
272	Level II Foot Musculoskeletal Procedures	T	16.56	$839.09	$409.74	$167.82
276	Bunion Procedures	T	19.19	$972.35	$500.14	$194.47
280	Diagnostic Arthroscopy	T	22.20	$1,124.86	$581.72	$224.97
281	Level I Surgical Arthroscopy	T	22.65	$1,147.66	$590.20	$229.53
282	Level II Surgical Arthroscopy	T	23.94	$1,213.03	$614.04	$242.61
286	Arthroscopically-Aided Procedures	T	26.76	$1,355.91	$802.41	$271.18
311	Level I ENT Procedures	T	1.43	$72.46	$20.57	$14.49
312	Level II ENT Procedures	T	7.26	$367.86	$178.31	$73.57
313	Level III ENT Procedures	T	15.81	$801.08	$411.09	$160.22
314	Level IV ENT Procedures	T	25.65	$1,299.67	$693.37	$259.93
*317	Implantation of Cochlear Device	T				
318	Nasal Cauterization/Packing	T	2.07	$104.89	$38.65	$20.98
319	Tonsil/Adenoid Procedures	T	17.30	$876.58	$480.02	$175.32
320	Thoracentesis/Lavage Procedures	T	3.17	$160.62	$79.33	$32.12
331	Level I Endoscopy Upper Airway	T	0.69	$34.96	$14.01	$6.99
332	Level II Endoscopy Upper Airway	T	9.74	$493.52	$244.98	$98.70
333	Level III Endoscopy Upper Airway	T	17.24	$873.54	$464.20	$174.71
336	Endoscopy Lower Airway	T	7.44	$376.98	$197.98	$75.40
339	Injection of Sclerosing Solution	T	1.02	$51.68	$19.66	$10.34
341	Level I Needle and Catheter Placement	T	0.13	$6.59	$2.94	$1.32
342	Level II Needle and Catheter Placement	T	3.20	$162.14	$80.23	$32.43
343	Level III Needle and Catheter Placement	T	9.52	$482.37	$224.87	$96.47
346	Placement Transvenous Caths/Cutdown	T	4.83	$244.73	$120.23	$48.95
347	Injection Procedures for Interventional Radiology.	T	2.93	$148.46	$62.15	$29.69
360	Removal/Revision, Pacemaker/Vascular Device.	T	6.09	$308.58	$140.12	$61.72
367	Vascular Ligation	T	17.59	$891.28	$449.06	$178.26
368	Vascular Repair/Fistula Construction	T	22.83	$1,156.78	$648.85	$231.36
369	Blood and Blood Product Exchange	T	4.33	$219.40	$97.18	$43.88

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ADDENDUM A.—LIST OF PROPOSED HOSPITAL OUTPATIENT AMBULATORY PAYMENT CLASSES WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COINSURANCE AMOUNTS—Continued

APC [1] [2]	Group title	Status indicator	Relative weight	Payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
396	Lymph Node Excisions	T	13.28	$672.89	$338.77	$134.58
397	Thyroid/Lymphadenectomy Procedures	T	18.36	$930.29	$496.86	$186.06
406	Esophageal Dilation without Endoscopy	T	4.31	$218.39	$108.48	$43.68
407	Esophagoscopy	T	7.06	$357.73	$189.84	$71.55
417	Diagnostic Upper GI Endoscopy	T	6.44	$326.31	$181.70	$65.26
418	Therapeutic Upper GI Endoscopy	T	7.59	$384.58	$214.25	$76.92
419	Small Intestine Endoscopy	T	7.13	$361.27	$164.08	$72.25
426	Diagnostic Lower GI Endoscopy	T	6.85	$347.09	$187.81	$69.42
427	Therapeutic Lower GI Endoscopy	T	8.22	$416.50	$224.19	$83.30
437	Therapeutic Anoscopy	T	2.91	$147.45	$76.61	$29.49
446	Diagnostic Sigmoidoscopy	T	2.59	$131.23	$65.09	$26.25
447	Therapeutic Proctosigmoidoscopy	T	6.87	$348.10	$184.76	$69.62
448	Therapeutic Flexible Sigmoidoscopy	T	5.37	$272.09	$141.25	$54.42
449	Complex GI Endoscopy	T	7.80	$395.22	$215.38	$79.04
451	Level I Anal/Rectal Procedures	T	2.56	$129.71	$54.24	$25.94
452	Level II Anal/Rectal Procedures	T	4.82	$244.23	$109.61	$48.85
453	Level III Anal/Rectal Procedures	T	16.87	$854.79	$445.22	$170.96
456	Endoscopic Retrograde Cholangio-Pancreatography (ERCP).	T	9.78	$495.55	$257.19	$99.11
458	Percutaneous Biliary Endoscopic Procedures.	T	7.23	$366.34	$181.59	$73.27
459	Peritoneal and Abdominal Procedures	T	18.06	$915.09	$496.52	$183.02
466	Hernia/Hydrocele Procedures	T	21.43	$1,085.85	$562.97	$217.17
470	Tube Procedures	T	2.22	$112.49	$54.92	$22.50
521	Level I Cystourethroscopy and other Genitourinary Procedures.	T	5.06	$256.39	$112.10	$51.28
522	Level II Cystourethroscopy and other Genitourinary Procedures.	T	10.46	$530.00	$262.39	$106.00
523	Level III Cystourethroscopy and other Genitourinary Procedures.	T	16.87	$854.79	$447.03	$170.96
524	Level IV Cystourethroscopy and other Genitourinary Procedures.	T	28.89	$1,463.84	$833.38	$292.77
527	Lithotripsy	T	51.56	$2,612.52	$1,372.95	$522.50
529	Simple Urinary Studies and Procedures	T	2.50	$126.67	$63.05	$25.33
530	Genitourinary Procedures	T	2.52	$127.69	$54.69	$25.54
531	Level I Urethral Procedures	T	18.94	$959.68	$527.26	$191.94
532	Level II Urethral Procedures	T	25.50	$1,292.07	$602.18	$258.41
536	Circumcision	T	13.17	$667.32	$326.57	$133.46
537	Penile Procedures	T	28.72	$1,455.23	$864.34	$291.05
538	Insertion of Penile Prosthesis	T	45.59	$2,310.02	$1,540.64	$462.00
546	Testes/Epididymis Procedures	T	17.14	$868.47	$453.81	$173.69
547	Prostate Biopsy	T	4.39	$222.44	$125.20	$44.49
550	Surgical Hysteroscopy	T	16.89	$855.81	$447.93	$171.16
551	Level I Laparoscopy	T	24.78	$1,255.59	$711.67	$251.12
552	Level II Laparoscopy	T	37.71	$1,910.75	$1,053.16	$382.15
561	Level I Female Reproductive Procedures	T	1.52	$77.02	$24.63	$15.40
562	Level II Female Reproductive Procedures	T	12.76	$646.54	$330.75	$129.31
563	Level III Female Reproductive Procedures	T	16.90	$856.31	$464.88	$171.26
567	D & C	T	13.61	$689.61	$364.09	$137.92
568	Infertility Procedures	T	2.49	$126.17	$49.49	$25.23
578	Pregnancy and Neonatal Care Procedures	T	1.26	$63.84	$33.90	$12.77
580	Vaginal Delivery	T	4.59	$232.57	$146.34	$46.51
586	Therapeutic Abortion	T	12.50	$633.37	$431.89	$126.67
587	Spontaneous Abortion	T	13.25	$671.37	$347.02	$134.27
600	Spinal Tap	T	2.63	$133.26	$61.47	$26.65
601	Level I Nervous System Injections	T	3.11	$157.58	$74.13	$31.52
602	Level II Nervous System Injections	T	3.33	$168.73	$87.69	$33.75
616	Implantation of Neurostimulator Electrodes	T	14.43	$731.16	$366.57	$146.23
617	Revision/Removal Neurological Device	T	11.56	$585.74	$287.59	$117.15
618	Implantation of Neurological Device	T	25.56	$1,295.11	$780.49	$259.02
631	Level I Nerve Procedures	T	12.98	$657.69	$333.80	$131.54
632	Level II Nerve Procedures	T	18.13	$918.64	$461.04	$183.73
648	Laser Retinal Procedures	T	3.94	$199.64	$95.15	$39.93
649	Laser Eye Procedures except Retinal	T	4.44	$224.97	$111.64	$44.99
651	Level I Anterior Segment Eye Procedures	T	7.24	$366.85	$174.70	$73.37
652	Level II Anterior Segment Eye Procedures	T	16.48	$835.03	$433.69	$167.01
667	Cataract Procedures	T	15.33	$776.40	$521.72	$155.28
668	Cataract Procedures with IOL Insert	T	19.28	$976.91	$530.87	$195.38
670	Corneal Transplant	T	29.23	$1,481.07	$847.50	$296.21
676	Posterior Segment Eye Procedures	T	6.30	$319.22	$140.35	$63.84
677	Strabismus/Muscle Procedures	T	16.26	$823.89	$436.63	$164.78
681	Level I Eye Procedures	T	1.67	$84.62	$30.51	$16.92
682	Level II Eye Procedures	T	3.54	$179.37	$81.36	$35.87
683	Level III Eye Procedures	T	10.19	$516.32	$257.87	$103.26
684	Level IV Eye Procedures	T	13.48	$683.02	$348.94	$136.60

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ADDENDUM A.—LIST OF PROPOSED HOSPITAL OUTPATIENT AMBULATORY PAYMENT CLASSES WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COINSURANCE AMOUNTS—Continued

APC[1][2]	Group title		Status indicator	Relative weight	Payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
690	Vitrectomy		T	30.54	$1,547.45	$852.02	$309.49
700	Plain Film		X	0.78	$39.52	$22.37	$7.90
706	Miscellaneous Radiological Procedures		X	1.96	$99.31	$57.63	$19.86
710	Computerized Axial Tomography		S	5.06	$256.39	$176.28	$51.28
716	Fluoroscopy		X	1.59	$80.56	$47.91	$16.11
720	Magnetic Resonance Angiography		S	6.34	$321.24	$206.11	$64.25
726	Magnetic Resonance Imaging		S	7.96	$403.33	$258.09	$80.67
728	Myelography		S	4.07	$206.22	$113.23	$41.24
730	Arthography		S	2.48	$125.66	$72.09	$25.13
736	Digestive Radiology		S	1.85	$93.74	$54.24	$18.75
737	Diagnostic Urography		S	2.81	$142.38	$86.56	$28.48
738	Therapeutic Radiologic Procedures		S	4.48	$227.00	$133.23	$45.40
739	Diagnostic Angiography and Venography		S	5.83	$295.40	$168.71	$59.08
746	Mammography		S	0.69	$34.96	$19.44	$6.99
747	Diagnostic Ultrasound Except Vascular		S	1.65	$83.60	$54.69	$16.72
749	Guidance under Ultrasound		X	2.44	$123.63	$76.16	$24.73
750	Therapeutic Radiation Treatment Planning		X	0.91	$46.11	$25.54	$9.22
751	Level I Therapeutic Radiation Treatment Preparation.		X	1.15	$58.27	$33.22	$11.65
752	Level II Therapeutic Radiation Treatment Preparation.		X	3.54	$179.37	$88.82	$35.87
757	Radiation Therapy		S	2.30	$116.54	$52.43	$23.31
758	Hyperthermic Therapies		S	3.41	$172.78	$76.84	$34.56
759	Brachytherapy and Complex Radioelement Applications.		S	7.98	$404.34	$160.01	$80.87
760	PET Scans		S	17.26	$874.55	$419.46	$174.91
*761	Standard Non-Imaging Nuclear Medicine		S	2.04	$103.37	$61.47	$20.67
*762	Complex Non-Imaging Nuclear Medicine		S	1.78	$90.19	$51.53	$18.04
771	Standard Planar Nuclear Medicine		S	3.78	$191.53	$116.84	$38.31
772	Complex Planar Nuclear Medicine		S	4.22	$213.83	$127.92	$42.77
781	Standard SPECT Nuclear Medicine		S	5.26	$266.52	$145.77	$53.30
782	Complex SPECT Nuclear Medicine		S	9.28	$470.21	$275.04	$94.04
*791	Standard Therapeutic Nuclear Medicine		S	15.83	$802.10	$562.06	$160.42
*792	Complex Therapeutic Nuclear Medicine		S	4.80	$243.21	$144.19	$48.64
861	Immunology Tests		X	0.13	$6.59	$3.62	$1.32
881	Level I Pathology		X	0.20	$10.13	$6.78	$2.03
882	Level II Pathology		X	0.39	$19.76	$11.75	$3.95
883	Level III Pathology		X	0.65	$32.94	$20.34	$6.59
900	Critical Care		V	7.44	$376.98	$144.87	$75.40
901	Level I Immunization		X	0.07	$3.55	$2.49	$0.71
*902	Level II Immunization		X	1.78	$90.19	$41.47	$18.04
*903	Level III Immunization		X	1.16	$58.78	$25.65	$11.76
906	Infusion Therapy except Chemotherapy		X	1.46	$73.98	$42.49	$14.80
907	Intramuscular Injections		X	0.85	$43.07	$11.98	$8.61
+91111	Low Level Clinic Visits	Well care and administrative	V	1.06	$53.71	$12.66	$10.74
91118	Low Level Clinic Visits	Skin and breast diseases	V	0.83	$42.06	$9.27	$8.41
91124	Low Level Clinic Visits	Musculoskeletal diseases	V	0.87	$44.08	$9.49	$8.82
91131	Low Level Clinic Visits	Ear, nose, mouth and throat diseases	V	0.81	$41.04	$9.04	$8.21
91133	Low Level Clinic Visits	Respiratory system diseases	V	0.80	$40.54	$8.59	$8.11
91136	Low Level Clinic Visits	Cardiovascular system diseases	V	0.85	$43.07	$8.61	$8.61
91141	Low Level Clinic Visits	Digestive system diseases	V	0.98	$49.66	$10.40	$9.93
91153	Low Level Clinic Visits	Kidney, urinary tract and male genital diseases.	V	0.91	$46.11	$9.27	$9.22
91156	Low Level Clinic Visits	Female genital system diseases	V	0.93	$47.12	$9.42	$9.42
*91157	Low Level Clinic Visits	Pregnancy and neonatal care	V	1.33	$67.39	$14.46	$13.48
91163	Low Level Clinic Visits	Nervous system diseases	V	0.98	$49.66	$10.17	$9.93
*91168	Low Level Clinic Visits	Eye diseases	V	0.98	$49.66	$10.62	$9.93
*91172	Low Level Clinic Visits	Trauma and poisoning	V	1.06	$53.71	$14.24	$10.74
*91178	Low Level Clinic Visits	Major signs, symptoms and findings	V	1.52	$77.02	$21.58	$15.40
91182	Low Level Clinic Visits	Endocrine, nutritional and metabolic diseases.	V	0.87	$44.08	$9.04	$8.82
*91186	Low Level Clinic Visits	Immunologic and hematologic diseases	V	1.09	$55.23	$11.30	$11.05
91188	Low Level Clinic Visits	Malignancy	V	0.72	$36.48	$8.14	$7.30
+91191	Low Level Clinic Visits	Psychiatric disorders	V	1.09	$55.23	$14.01	$11.05
91197	Low Level Clinic Visits	Infectious disease	V	1.02	$51.68	$11.53	$10.34
+91199	Low Level Clinic Visits	Unknown cause of mortality	V	1.31	$66.38	$20.79	$13.28
+91311	Mid Level Clinic Visits	Well care and administrative	V	1.06	$53.71	$12.66	$10.74
91318	Mid Level Clinic Visits	Skin and breast diseases	V	0.98	$49.66	$9.93	$9.93
91324	Mid Level Clinic Visits	Musculoskeletal diseases	V	0.98	$49.66	$9.93	$9.93
91331	Mid Level Clinic Visits	Ear, nose, mouth and throat diseases	V	0.94	$47.63	$9.53	$9.53
91333	Mid Level Clinic Visits	Respiratory system diseases	V	0.93	$47.12	$9.42	$9.42
91336	Mid Level Clinic Visits	Cardiovascular system diseases	V	1.00	$50.67	$10.13	$10.13
91341	Mid Level Clinic Visits	Digestive system diseases	V	1.00	$50.67	$10.13	$10.13
91353	Mid Level Clinic Visits	Kidney, urinary tract and male genital diseases.	V	1.04	$52.70	$10.54	$10.54

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ADDENDUM A.—LIST OF PROPOSED HOSPITAL OUTPATIENT AMBULATORY PAYMENT CLASSES WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COINSURANCE AMOUNTS—Continued

APC [1] [2]	Group title		Status indicator	Relative weight	Payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
91356	Mid Level Clinic Visits	Female genital system diseases	V	1.06	$53.71	$10.74	$10.74
*91357	Mid Level Clinic Visits	Pregnancy and neonatal care	V	1.22	$61.82	$12.66	$12.36
91363	Mid Level Clinic Visits	Nervous system diseases	V	1.04	$52.70	$10.54	$10.54
*91368	Mid Level Clinic Visits	Eye diseases	V	0.87	$44.08	$8.82	$8.82
*91372	Mid Level Clinic Visits	Trauma and poisoning	V	1.06	$53.71	$10.85	$10.74
*91378	Mid Level Clinic Visits	Major signs, symptoms and findings	V	1.13	$57.26	$11.45	$11.45
91382	Mid Level Clinic Visits	Endocrine, nutritional and metabolic diseases.	V	1.00	$50.67	$10.13	$10.13
*91386	Mid Level Clinic Visits	Immunologic and hematologic diseases	V	1.04	$52.70	$10.54	$10.54
91388	Mid Level Clinic Visits	Malignancy	V	0.83	$42.06	$8.41	$8.41
+91391	Mid Level Clinic Visits	Psychiatric disorders	V	1.09	$55.23	$14.01	$11.05
91397	Mid Level Clinic Visits	Infectious disease	V	1.06	$53.71	$10.74	$10.74
+91399	Mid Level Clinic Visits	Unknown cause of mortality	V	1.31	$66.38	$20.79	$13.28
+91511	High Level Clinic Visits	Well care and administrative	V	1.06	$53.71	$12.66	$10.74
91518	High Level Clinic Visits	Skin and breast diseases	V	1.69	$85.63	$19.21	$17.13
91524	High Level Clinic Visits	Musculoskeletal diseases	V	1.37	$69.42	$15.37	$13.88
91531	High Level Clinic Visits	Ear, nose, mouth and throat diseases	V	1.31	$66.38	$14.92	$13.28
91533	High Level Clinic Visits	Respiratory system diseases	V	1.33	$67.39	$13.79	$13.48
91536	High Level Clinic Visits	Cardiovascular system diseases	V	1.43	$72.46	$15.37	$14.49
91541	High Level Clinic Visits	Digestive system diseases	V	1.50	$76.00	$16.05	$15.20
91553	High Level Clinic Visits	Kidney, urinary tract and male genital diseases.	V	1.30	$65.87	$14.01	$13.17
91556	High Level Clinic Visits	Female genital system diseases	V	1.43	$72.46	$14.49	$14.49
91557	High Level Clinic Visits	Pregnancy and neonatal care	V	1.81	$91.71	$22.15	$18.34
91563	High Level Clinic Visits	Nervous system diseases	V	1.50	$76.00	$16.72	$15.20
91568	High Level Clinic Visits	Eye diseases	V	1.31	$66.38	$13.79	$13.28
91572	High Level Clinic Visits	Trauma and poisoning	V	1.69	$85.63	$22.15	$17.13
91578	High Level Clinic Visits	Major signs, symptoms and findings	V	1.89	$95.77	$29.15	$19.15
91582	High Level Clinic Visits	Endocrine, nutritional and metabolic diseases.	V	1.41	$71.44	$15.14	$14.29
91586	High Level Clinic Visits	Immunologic and hematologic diseases	V	1.65	$83.60	$18.98	$16.72
91588	High Level Clinic Visits	Malignancy	V	1.09	$55.23	$12.43	$11.05
91591	High Level Clinic Visits	Psychiatric disorders	V	1.57	$79.55	$21.92	$15.91
91597	High Level Clinic Visits	Infectious disease	V	1.76	$89.18	$19.66	$17.84
+91599	High Level Clinic Visits	Unknown cause of mortality	V	1.31	$66.38	$20.79	$13.28
919	Electroconvulsive Therapy		S	3.17	$160.62	$80.00	$32.12
920	Biofeedback and other Training		S	1.17	$59.28	$29.61	$11.86
*921	Diabetes Education		S				
926	Dialysis for other than ESRD patients		S	4.28	$216.87	$69.83	$43.37
928	Alimentary Tests		X	3.11	$157.58	$83.85	$31.52
930	Minor Eye Examinations		X	1.02	$51.68	$22.83	$10.34
931	Level I Eye Tests		X	0.74	$37.50	$21.47	$7.50
932	Level II Eye Tests		X	2.52	$127.69	$65.09	$25.54
936	Fitting of Vision Aids		X	0.52	$26.35	$9.49	$5.27
940	Otorhinolaryngologic Function Tests		X	3.04	$154.04	$51.98	$30.81
941	Level I Audiometry		X	0.74	$37.50	$13.56	$7.50
942	Level II Audiometry		X	1.48	$74.99	$22.15	$15.00
947	Resuscitation and Cardioversion		S	4.07	$206.22	$109.61	$41.24
948	Cardiac Rehabilitation		X	0.81	$41.04	$16.95	$8.21
949	Cardiovascular Stress Test		X	1.46	$73.98	$62.83	$14.80
950	Electrocardiogram (ECG)		X	0.35	$17.73	$15.82	$3.55
+95111	Low Level ER Visits	Well care and administrative	V	1.06	$53.71	$12.66	$10.74
95118	Low Level ER Visits	Skin and breast diseases	V	1.17	$59.28	$19.21	$11.86
95124	Low Level ER Visits	Musculoskeletal diseases	V	1.17	$59.28	$19.89	$11.86
95131	Low Level ER Visits	Ear, nose, mouth and throat diseases	V	1.11	$56.24	$17.63	$11.25
95133	Low Level ER Visits	Respiratory system diseases	V	1.15	$58.27	$18.31	$11.65
95136	Low Level ER Visits	Cardiovascular system diseases	V	1.24	$62.83	$19.89	$12.57
95141	Low Level ER Visits	Digestive system diseases	V	1.30	$65.87	$21.02	$13.17
95153	Low Level ER Visits	Kidney, urinary tract and male genital diseases.	V	1.43	$72.46	$24.41	$14.49
95156	Low Level ER Visits	Female genital system diseases	V	1.41	$71.44	$23.73	$14.29
95157	Low Level ER Visits	Pregnancy and neonatal care	V	1.44	$72.96	$24.18	$14.59
95163	Low Level ER Visits	Nervous system diseases	V	1.31	$66.38	$22.83	$13.28
95168	Low Level ER Visits	Eye diseases	V	1.20	$60.80	$20.79	$12.16
95172	Low Level ER Visits	Trauma and poisoning	V	1.28	$64.86	$22.15	$12.97
95178	Low Level ER Visits	Major signs, symptoms and findings	V	2.02	$102.35	$37.97	$20.47
95182	Low Level ER Visits	Endocrine, nutritional and metabolic diseases.	V	1.50	$76.00	$24.63	$15.20
95186	Low Level ER Visits	Immunologic and hematologic diseases	V	1.43	$72.46	$25.76	$14.49
95188	Low Level ER Visits	Malignancy	V	1.52	$77.02	$26.44	$15.40
95191	Low Level ER Visits	Psychiatric Disorders	V	1.09	$55.23	$14.01	$11.05
95197	Low Level ER Visits	Infectious disease	V	1.24	$62.83	$20.57	$12.57
+95199	Low Level ER Visits	Unknown cause of mortality	V	1.31	$66.38	$20.79	$13.28
+95311	Mid Level ER Visits	Well care and administrative	V	1.06	$53.71	$12.66	$10.74
95318	Mid Level ER Visits	Skin and breast diseases	V	1.89	$95.77	$34.80	$19.15

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APC [1] [2]	Group title		Status indicator	Relative weight	Payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
95324	Mid Level ER Visits	Musculoskeletal diseases	V	1.78	$90.19	$32.32	$18.04
95331	Mid Level ER Visits	Ear, nose, mouth and throat diseases	V	1.81	$91.71	$31.64	$18.34
95333	Mid Level ER Visits	Respiratory system diseases	V	1.91	$96.78	$33.67	$19.36
95336	Mid Level ER Visits	Cardiovascular system diseases	V	2.02	$102.35	$36.16	$20.47
95341	Mid Level ER Visits	Digestive system diseases	V	2.02	$102.35	$36.61	$20.47
95353	Mid Level ER Visits	Kidney, urinary tract and male genital diseases.	V	2.06	$104.38	$38.19	$20.88
95356	Mid Level ER Visits	Female genital system diseases	V	2.04	$103.37	$36.61	$20.67
95357	Mid Level ER Visits	Pregnancy and neonatal care	V	2.06	$104.38	$39.78	$20.88
95363	Mid Level ER Visits	Nervous system diseases	V	2.00	$101.34	$37.29	$20.27
95368	Mid Level ER Visits	Eye diseases	V	1.69	$85.63	$33.00	$17.13
95372	Mid Level ER Visits	Trauma and poisoning	V	2.02	$102.35	$38.87	$20.47
95378	Mid Level ER Visits	Major signs, symptoms and findings	V	3.07	$155.56	$58.76	$31.11
95382	Mid Level ER Visits	Endocrine, nutritional and metabolic diseases.	V	2.30	$116.54	$43.62	$23.31
95386	Mid Level ER Visits	Immunologic and hematologic diseases	V	2.39	$121.10	$47.01	$24.22
95388	Mid Level ER Visits	Malignancy	V	2.15	$108.94	$41.13	$21.79
95391	Mid Level ER Visits	Psychiatric Disorders	V	2.00	$101.34	$35.93	$20.27
95397	Mid Level ER Visits	Infectious disease	V	1.98	$100.33	$36.61	$20.07
+95399	Mid Level ER Visits	Unknown cause of mortality	V	1.31	$66.38	$20.79	$13.28
+95511	High Level ER Visits	Well care and administrative	V	1.06	$53.71	$12.66	$10.74
95518	High Level ER Visits	Skin and breast diseases	V	2.61	$132.25	$46.56	$26.45
95524	High Level ER Visits	Musculoskeletal diseases	V	2.44	$123.63	$41.36	$24.73
95531	High Level ER Visits	Ear, nose, mouth and throat diseases	V	2.56	$129.71	$44.07	$25.94
95533	High Level ER Visits	Respiratory system diseases	V	3.19	$161.64	$54.69	$32.33
95536	High Level ER Visits	Cardiovascular system diseases	V	3.17	$160.62	$54.69	$32.12
95541	High Level ER Visits	Digestive system diseases	V	2.89	$146.43	$54.69	$29.29
95553	High Level ER Visits	Kidney, urinary tract and male genital diseases.	V	2.89	$146.43	$54.69	$29.29
95556	High Level ER Visits	Female genital system diseases	V	2.73	$138.33	$50.85	$27.67
95557	High Level ER Visits	Pregnancy and neonatal care	V	2.93	$148.46	$54.92	$29.69
95563	High Level ER Visits	Nervous system diseases	V	3.04	$154.04	$58.08	$30.81
95568	High Level ER Visits	Eye diseases	V	2.31	$117.05	$40.00	$23.41
95572	High Level ER Visits	Trauma and poisoning	V	2.74	$138.83	$50.17	$27.77
95578	High Level ER Visits	Major signs, symptoms and findings	V	6.85	$347.09	$148.48	$69.42
95582	High Level ER Visits	Endocrine, nutritional and metabolic diseases.	V	3.28	$166.20	$64.64	$33.24
95586	High Level ER Visits	Immunologic and hematologic diseases	V	3.70	$187.48	$74.35	$37.50
95588	High Level ER Visits	Malignancy	V	3.67	$185.96	$61.70	$37.19
95591	High Level ER Visits	Psychiatric Disorders	V	3.48	$176.33	$62.38	$35.27
95597	High Level ER Visits	Infectious disease	V	2.81	$142.38	$53.34	$28.48
+95599	High Level ER Visits	Unknown cause of mortality	V	1.31	$66.38	$20.79	$13.28
956	Continuous ECG and Blood Pressure Monitoring.		X	1.11	$56.24	$55.82	$11.25
957	Echocardiography		S	2.83	$143.39	$117.07	$28.68
958	Diagnostic Cardiac Catheterization		T	26.11	$1,322.98	$659.47	$264.60
960	Cardiac Electrophysiologic Tests/Procedures.		S	4.24	$214.84	$144.41	$42.97
966	Electronic Analysis of Pacemakers/other Devices.		X	0.39	$19.76	$12.43	$3.95
967	Non-Invasive Vascular Studies		X	1.70	$86.14	$57.40	$17.23
968	Vascular Ultrasound		X	2.37	$120.09	$79.55	$24.02
969	Hyperbaric Oxygen		S	2.65	$134.27	$141.70	$26.85
971	Level I Pulmonary Tests		X	0.78	$39.52	$21.47	$7.90
972	Level II Pulmonary Tests		X	1.02	$51.68	$29.38	$10.34
973	Level III Pulmonary Tests		S	1.89	$95.77	$55.82	$19.15
976	Pulmonary Therapy		S	0.44	$22.29	$14.92	$4.46
977	Allergy Tests		X	0.63	$31.92	$12.66	$6.38
978	Allergy Injections		X	0.31	$15.71	$3.39	$3.14
979	Extended EEG Studies and Sleep Studies		S	10.17	$515.31	$288.83	$103.06
980	Electroencephalogram		S	2.15	$108.94	$57.86	$21.79
*981	Level I Nerve and Muscle Tests		X	1.46	$73.98	$41.81	$14.80
*982	Level II Nerve and Muscle Tests		X	1.39	$70.43	$38.87	$14.09
987	Subcutaneous or Intramuscular Chemotherapy.		S	0.65	$32.94	$13.33	$6.59
988	Chemotherapy except by Extended Infusion.		S	4.15	$210.28	$97.52	$42.06
989	Chemotherapy by Extended Infusion		S	1.72	$87.15	$40.68	$17.43
990	Photochemotherapy		S	0.43	$21.79	$8.14	$4.36
997	Manipulation Therapy		S	0.69	$34.96	$7.23	$6.99
999	Therapeutic Phlebotomy		X	0.43	$21.79	$10.85	$4.36

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
00100	N	Anesth, skin surgery					
00102	N	Anesth, repair of cleft lip					
00103	N	Anesth, blepharoplasty					
00104	N	Anesth for electroshock					
00120	N	Anesthesia for ear surgery					
00124	N	Anesthesia for ear exam					
00126	N	Anesth, tympanotomy					
00140	N	Anesth, procedures on eye					
00142	N	Anesthesia for lens surgery					
00144	N	Anesth, corneal transplant					
00145	N	Anesth, vitrectomy					
00147	N	Anesth, iridectomy					
00148	N	Anesthesia for eye exam					
00160	N	Anesth, nose, sinus surgery					
00162	N	Anesth, nose, sinus surgery					
00164	N	Anesth, biopsy of nose					
00170	N	Anesth, procedure on mouth					
00172	N	Anesth, cleft palate repair					
00174	C	Anesth, pharyngeal surgery					
00176	C	Anesth, pharyngeal surgery					
00190	N	Anesth, facial bone surgery					
00192	C	Anesth, facial bone surgery					
00210	N	Anesth, open head surgery					
00212	N	Anesth, skull drainage					
00214	C	Anesth, skull drainage					
00215	C	Anesth, skull fracture					
00216	N	Anesth, head vessel surgery					
00218	N	Anesth, special head surgery					
00220	N	Anesth, spinal fluid shunt					
00222	N	Anesth, head nerve surgery					
00300	N	Anesth, skin surgery, neck					
00320	N	Anesth, neck organ surgery					
00322	N	Anesth, biopsy of thyroid					
00350	N	Anesth, neck vessel surgery					
00352	N	Anesth, neck vessel surgery					
00400	N	Anesth, chest skin surgery					
00402	N	Anesth, surgery of breast					
00404	C	Anesth, surgery of breast					
00406	C	Anesth, surgery of breast					
00410	N	Anesth, correct heart rhythm					
00420	N	Anesth, skin surgery, back					
00450	N	Anesth, surgery of shoulder					
00452	C	Anesth, surgery of shoulder					
00454	N	Anesth, collarbone biopsy					
00470	N	Anesth, removal of rib					
00472	N	Anesth, chest wall repair					
00474	C	Anesth, surgery of rib(s)					
00500	N	Anesth, esophageal surgery					
00520	N	Anesth, chest procedure					
00522	N	Anesth, chest lining biopsy					
00524	C	Anesth, chest drainage					
00528	N	Anesth, chest partition view					
00530	C	Anesth, pacemaker insertion					
00532	N	Anesth, vascular access					
00534	N	Anesth, cardioverter/defib					
00540	C	Anesth, chest surgery					
00542	C	Anesth, release of lung					
00544	C	Anesth, chest lining removal					
00546	C	Anesth, lung,chest wall surg					
00548	N	Anesth, trachea,bronchi surg					
00560	C	Anesth, open heart surgery					
00562	C	Anesth, open heart surgery					
00580	C	Anesth,heart/lung transplant					
00600	N	Anesth, spine, cord surgery					
00604	C	Anesth, surgery of vertebra					
00620	N	Anesth, spine, cord surgery					
00622	C	Anesth, removal of nerves					
00630	N	Anesth, spine, cord surgery					
00632	C	Anesth, removal of nerves					
00634	C	Anesth for chemonucleolysis					
00670	C	Anesth, spine, cord surgery					
00700	N	Anesth, abdominal wall surg					
00702	N	Anesth, for liver biopsy					
00730	N	Anesth, abdominal wall surg					
00740	N	Anesth, gi visualization					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
00750	N	Anesth, repair of hernia					
00752	N	Anesth, repair of hernia					
00754	N	Anesth, repair of hernia					
00756	N	Anesth, repair of hernia					
00770	N	Anesth, blood vessel repair					
00790	N	Anesth, surg upper abdomen					
00792	C	Anesth, part liver removal					
00794	C	Anesth, pancreas removal					
00796	C	Anesth, for liver transplant					
00800	N	Anesth, abdominal wall surg					
00802	C	Anesth, fat layer removal					
00810	N	Anesth, intestine endoscopy					
00820	N	Anesth, abdominal wall surg					
00830	N	Anesth, repair of hernia					
00832	N	Anesth, repair of hernia					
00840	N	Anesth, surg lower abdomen					
00842	N	Anesth, amniocentesis					
00844	C	Anesth, pelvis surgery					
00846	C	Anesth, hysterectomy					
00848	C	Anesth, pelvic organ surg					
00850	C	Anesth, cesarean section					
00855	C	Anesth, hysterectomy					
00857	C	Analgesia, labor & c-section					
00860	N	Anesth, surgery of abdomen					
00862	N	Anesth, kidney, ureter surg					
00864	C	Anesth, removal of bladder					
00865	C	Anesth, removal of prostate					
00866	C	Anesth, removal of adrenal					
00868	C	Anesth, kidney transplant					
00870	N	Anesth, bladder stone surg					
00872	N	Anesth,kidney stone destruct					
00873	N	Anesth,kidney stone destruct					
00880	N	Anesth, abdomen vessel surg					
00882	C	Anesth, major vein ligation					
00884	C	Anesth, major vein revision					
00900	N	Anesth, perineal procedure					
00902	N	Anesth, anorectal surgery					
00904	C	Anesth, perineal surgery					
00906	N	Anesth, removal of vulva					
00908	C	Anesth, removal of prostate					
00910	N	Anesth, bladder surgery					
00912	N	Anesth, bladder tumor surg					
00914	N	Anesth, removal of prostate					
00916	N	Anesth, bleeding control					
00918	N	Anesth, stone removal					
00920	N	Anesth, genitalia surgery					
00922	N	Anesth, sperm duct surgery					
00924	N	Anesth, testis exploration					
00926	N	Anesth, removal of testis					
00928	C	Anesth, removal of testis					
00930	N	Anesth, testis suspension					
00932	C	Anesth, amputation of penis					
00934	C	Anesth, penis, nodes removal					
00936	C	Anesth, penis, nodes removal					
00938	N	Anesth, insert penis device					
00940	N	Anesth, vaginal procedures					
00942	N	Anesth, surgery on vagina					
00944	C	Anesth, vaginal hysterectomy					
00946	N	Anesth, vaginal delivery					
00948	N	Anesth, repair of cervix					
00950	N	Anesth, vaginal endoscopy					
00952	N	Anesth, uterine endoscopy					
00955	C	Analgesia, vaginal delivery					
01000	N	Anesth, skin surgery, pelvis					
01110	N	Anesth, skin surgery, pelvis					
01120	N	Anesth, pelvis surgery					
01130	N	Anesth, body cast procedure					
01140	C	Anesth, amputation at pelvis					
01150	C	Anesth, pelvic tumor surgery					
01160	N	Anesth, pelvis procedure					
01170	N	Anesth, pelvis surgery					
01180	N	Anesth, pelvis nerve removal					
01190	C	Anesth, pelvis nerve removal					
01200	N	Anesth, hip joint procedure					
01202	N	Anesth, arthroscopy of hip					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
01210	N	Anesth, hip joint surgery					
01212	C	Anesth, hip disarticulation					
01214	C	Anesth, replacement of hip					
01220	N	Anesth, procedure on femur					
01230	N	Anesth, surgery of femur					
01232	C	Anesth, amputation of femur					
01234	C	Anesth, radical femur surg					
01240	N	Anesth, upper leg skin surg					
01250	N	Anesth, upper leg surgery					
01260	N	Anesth, upper leg veins surg					
01270	N	Anesth, thigh arteries surg					
01272	C	Anesth, femoral artery surg					
01274	C	Anesth, femoral embolectomy					
01300	N	Anesth, skin surgery, knee					
01320	N	Anesth, knee area surgery					
01340	N	Anesth, knee area procedure					
01360	N	Anesth, knee area surgery					
01380	N	Anesth, knee joint procedure					
01382	N	Anesth, knee arthroscopy					
01390	N	Anesth, knee area procedure					
01392	N	Anesth, knee area surgery					
01400	N	Anesth, knee joint surgery					
01402	C	Anesth, replacement of knee					
01404	C	Anesth, amputation at knee					
01420	N	Anesth, knee joint casting					
01430	N	Anesth, knee veins surgery					
01432	N	Anesth, knee vessel surg					
01440	N	Anesth, knee arteries surg					
01442	C	Anesth, knee artery surg					
01444	C	Anesth, knee artery repair					
01460	N	Anesth, lower leg skin surg					
01462	N	Anesth, lower leg procedure					
01464	N	Anesth, ankle arthroscopy					
01470	N	Anesth, lower leg surgery					
01472	N	Anesth, achilles tendon surg					
01474	N	Anesth, lower leg surgery					
01480	N	Anesth, lower leg bone surg					
01482	N	Anesth, radical leg surgery					
01484	N	Anesth, lower leg revision					
01486	C	Anesth, ankle replacement					
01490	N	Anesth, lower leg casting					
01500	N	Anesth, leg arteries surg					
01502	C	Anesth, lowerleg embolectomy					
01520	N	Anesth, lower leg vein surg					
01522	N	Anesth, lower leg vein surg					
01600	N	Anesth, shoulder skin surg					
01610	N	Anesth, surgery of shoulder					
01620	N	Anesth, shoulder procedure					
01622	N	Anesth, shoulder arthroscopy					
01630	N	Anesth, surgery of shoulder					
01632	C	Anesth, surgery of shoulder					
01634	C	Anesth, shoulder joint amput					
01636	C	Anesth, forequarter amput					
01638	C	Anesth, shoulder replacement					
01650	N	Anesth, shoulder artery surg					
01652	C	Anesth, shoulder vessel surg					
01654	C	Anesth, shoulder vessel surg					
01656	C	Anesth, arm-leg vessel surg					
01670	N	Anesth, shoulder vein surg					
01680	N	Anesth, shoulder casting					
01682	N	Anesth, airplane cast					
01700	N	Anesth, elbow area skin surg					
01710	N	Anesth, elbow area surgery					
01712	N	Anesth, upperarm tendon surg					
01714	N	Anesth, upperarm tendon surg					
01716	N	Anesth, biceps tendon repair					
01730	N	Anesth, upperarm procedure					
01732	N	Anesth, elbow arthroscopy					
01740	N	Anesth, upper arm surgery					
01742	N	Anesth, humerus surgery					
01744	N	Anesth, humerus repair					
01756	C	Anesth, radical humerus surg					
01758	N	Anesth, humeral lesion surg					
01760	N	Anesth, elbow replacement					
01770	N	Anesth, upperarm artery surg					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
01772	C	Anesth, upperarm embolectomy	.....	.....	.....	.....	.....
01780	N	Anesth, upper arm vein surg	.....	.....	.....	.....	.....
01782	C	Anesth, upperarm vein repair	.....	.....	.....	.....	.....
01784	N	Anesth, av fistula repair	.....	.....	.....	.....	.....
01800	N	Anesth, lower arm skin surg	.....	.....	.....	.....	.....
01810	N	Anesth, lower arm surgery	.....	.....	.....	.....	.....
01820	N	Anesth, lower arm procedure	.....	.....	.....	.....	.....
01830	N	Anesth, lower arm surgery	.....	.....	.....	.....	.....
01832	N	Anesth, wrist replacement	.....	.....	.....	.....	.....
01840	N	Anesth, lowerarm artery surg	.....	.....	.....	.....	.....
01842	C	Anesth, lowerarm embolectomy	.....	.....	.....	.....	.....
01844	N	Anesth, vascular shunt surg	.....	.....	.....	.....	.....
01850	N	Anesth, lower arm vein surg	.....	.....	.....	.....	.....
01852	C	Anesth, lowerarm vein repair	.....	.....	.....	.....	.....
01860	N	Anesth, lower arm casting	.....	.....	.....	.....	.....
01900	N	Anesth, uterus/tube inject	.....	.....	.....	.....	.....
01902	C	Anesth, burr holes, skull	.....	.....	.....	.....	.....
01904	C	Anesth, skull x-ray inject	.....	.....	.....	.....	.....
01906	N	Anesth, lumbar myelography	.....	.....	.....	.....	.....
01908	N	Anesth, cervical myelography	.....	.....	.....	.....	.....
01910	N	Anesth, skull myelography	.....	.....	.....	.....	.....
01912	N	Anesth, lumbar discography	.....	.....	.....	.....	.....
01914	N	Anesth, cervical discography	.....	.....	.....	.....	.....
01916	C	Anesth, head arteriogram	.....	.....	.....	.....	.....
01918	C	Anesth, limb arteriogram	.....	.....	.....	.....	.....
01920	N	Anesth, catheterize heart	.....	.....	.....	.....	.....
01921	C	Anesth, vessel surgery	.....	.....	.....	.....	.....
01922	N	Anesth, cat or MRI scan	.....	.....	.....	.....	.....
01990	C	Support for organ donor	.....	.....	.....	.....	.....
01995	N	Regional anesthesia, limb	.....	.....	.....	.....	.....
01996	N	Manage daily drug therapy	.....	.....	.....	.....	.....
01999	N	Unlisted anesth procedure	.....	.....	.....	.....	.....
10040	T	Acne surgery of skin abscess	131	1.94	$102.84	$36.61	$20.57
10060	T	Drainage of skin abscess	131	1.94	$102.84	$36.61	$20.57
10061	T	Drainage of skin abscess	131	1.94	$102.84	$36.61	$20.57
10080	T	Drainage of pilonidal cyst	131	1.94	$102.84	$36.61	$20.57
10081	T	Drainage of pilonidal cyst	131	1.94	$102.84	$36.61	$20.57
10120	T	Remove foreign body	131	1.94	$102.84	$36.61	$20.57
10121	T	Remove foreign body	163	10.69	$565.14	$264.65	$113.03
10140	T	Drainage of hematoma/fluid	131	1.94	$102.84	$36.61	$20.57
10160	T	Puncture drainage of lesion	131	1.94	$102.84	$36.61	$20.57
10180	T	Complex drainage, wound	131	1.94	$102.84	$36.61	$20.57
11000	T	Debride infected skin	151	1.74	$92.07	$35.71	$18.41
11001	T	Debride infect skin add	151	1.74	$92.07	$35.71	$18.41
11010	T	Debride skin, fx	163	10.69	$565.14	$264.65	$113.03
11011	T	Debride skin/muscle, fx	163	10.69	$565.14	$264.65	$113.03
11012	T	Debride skin/muscle/bone, fx	163	10.69	$565.14	$264.65	$113.03
11040	T	Debride skin partial	151	1.74	$92.07	$35.71	$18.41
11041	T	Debride skin full	151	1.74	$92.07	$35.71	$18.41
11042	T	Debride skin/tissue	151	1.74	$92.07	$35.71	$18.41
11043	T	Debride tissue/muscle	162	5.67	$299.71	$125.43	$59.94
11044	T	Debride tissue/muscle/bone	162	5.67	$299.71	$125.43	$59.94
11055	T	Trim skin lesion	151	1.74	$92.07	$35.71	$18.41
11056	T	Trim 2 to 4 skin lesions	151	1.74	$92.07	$35.71	$18.41
11057	T	Trim over 4 skin lesions	151	1.74	$92.07	$35.71	$18.41
11100	T	Biopsy of skin lesion	161	3.50	$185.12	$75.48	$37.02
11101	T	Biopsy, each added lesion	161	3.50	$185.12	$75.48	$37.02
11200	T	Removal of skin tags	151	1.74	$92.07	$35.71	$18.41
11201	T	Removal of added skin tags	151	1.74	$92.07	$35.71	$18.41
11300	T	Shave skin lesion	151	1.74	$92.07	$35.71	$18.41
11301	T	Shave skin lesion	151	1.74	$92.07	$35.71	$18.41
11302	T	Shave skin lesion	151	1.74	$92.07	$35.71	$18.41
11303	T	Shave skin lesion	151	1.74	$92.07	$35.71	$18.41
11305	T	Shave skin lesion	151	1.74	$92.07	$35.71	$18.41
11306	T	Shave skin lesion	151	1.74	$92.07	$35.71	$18.41
11307	T	Shave skin lesion	151	1.74	$92.07	$35.71	$18.41
11308	T	Shave skin lesion	151	1.74	$92.07	$35.71	$18.41
11310	T	Shave skin lesion	151	1.74	$92.07	$35.71	$18.41
11311	T	Shave skin lesion	151	1.74	$92.07	$35.71	$18.41
11312	T	Shave skin lesion	151	1.74	$92.07	$35.71	$18.41
11313	T	Shave skin lesion	151	1.74	$92.07	$35.71	$18.41
11400	T	Removal of skin lesion	161	3.50	$185.12	$75.48	$37.02
11401	T	Removal of skin lesion	161	3.50	$185.12	$75.48	$37.02
11402	T	Removal of skin lesion	161	3.50	$185.12	$75.48	$37.02
11403	T	Removal of skin lesion	161	3.50	$185.12	$75.48	$37.02

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
11404	T	Removal of skin lesion	162	5.67	$299.71	$125.43	$59.94
11406	T	Removal of skin lesion	163	10.69	$565.14	$264.65	$113.03
11420	T	Removal of skin lesion	161	3.50	$185.12	$75.48	$37.02
11421	T	Removal of skin lesion	161	3.50	$185.12	$75.48	$37.02
11422	T	Removal of skin lesion	161	3.50	$185.12	$75.48	$37.02
11423	T	Removal of skin lesion	161	3.50	$185.12	$75.48	$37.02
11424	T	Removal of skin lesion	162	5.67	$299.71	$125.43	$59.94
11426	T	Removal of skin lesion	163	10.69	$565.14	$264.65	$113.03
11440	T	Removal of skin lesion	161	3.50	$185.12	$75.48	$37.02
11441	T	Removal of skin lesion	161	3.50	$185.12	$75.48	$37.02
11442	T	Removal of skin lesion	161	3.50	$185.12	$75.48	$37.02
11443	T	Removal of skin lesion	161	3.50	$185.12	$75.48	$37.02
11444	T	Removal of skin lesion	162	5.67	$299.71	$125.43	$59.94
11446	T	Removal of skin lesion	163	10.69	$565.14	$264.65	$113.03
11450	T	Removal, sweat gland lesion	163	10.69	$565.14	$264.65	$113.03
11451	T	Removal, sweat gland lesion	163	10.69	$565.14	$264.65	$113.03
11462	T	Removal, sweat gland lesion	163	10.69	$565.14	$264.65	$113.03
11463	T	Removal, sweat gland lesion	163	10.69	$565.14	$264.65	$113.03
11470	T	Removal, sweat gland lesion	163	10.69	$565.14	$264.65	$113.03
11471	T	Removal, sweat gland lesion	163	10.69	$565.14	$264.65	$113.03
11600	T	Removal of skin lesion	161	3.50	$185.12	$75.48	$37.02
11601	T	Removal of skin lesion	161	3.50	$185.12	$75.48	$37.02
11602	T	Removal of skin lesion	161	3.50	$185.12	$75.48	$37.02
11603	T	Removal of skin lesion	161	3.50	$185.12	$75.48	$37.02
11604	T	Removal of skin lesion	162	5.67	$299.71	$125.43	$59.94
11606	T	Removal of skin lesion	163	10.69	$565.14	$264.65	$113.03
11620	T	Removal of skin lesion	161	3.50	$185.12	$75.48	$37.02
11621	T	Removal of skin lesion	161	3.50	$185.12	$75.48	$37.02
11622	T	Removal of skin lesion	161	3.50	$185.12	$75.48	$37.02
11623	T	Removal of skin lesion	161	3.50	$185.12	$75.48	$37.02
11624	T	Removal of skin lesion	163	10.69	$565.14	$264.65	$113.03
11626	T	Removal of skin lesion	163	10.69	$565.14	$264.65	$113.03
11640	T	Removal of skin lesion	161	3.50	$185.12	$75.48	$37.02
11641	T	Removal of skin lesion	161	3.50	$185.12	$75.48	$37.02
11642	T	Removal of skin lesion	161	3.50	$185.12	$75.48	$37.02
11643	T	Removal of skin lesion	161	3.50	$185.12	$75.48	$37.02
11644	T	Removal of skin lesion	163	10.69	$565.14	$264.65	$113.03
11646	T	Removal of skin lesion	163	10.69	$565.14	$264.65	$113.03
11719	T	Trim nail(s)	137	0.46	$24.49	$4.90	$4.90
11720	T	Debride nail, 1–5	137	0.46	$24.49	$4.90	$4.90
11721	T	Debride nail, 6 or more	137	0.46	$24.49	$4.90	$4.90
11730	T	Removal of nail plate	151	1.74	$92.07	$35.71	$18.41
11731	T	Removal of second nail plate	151	1.74	$92.07	$35.71	$18.41
11732	T	Remove additional nail plate	151	1.74	$92.07	$35.71	$18.41
11740	T	Drain blood from under nail	137	0.46	$24.49	$4.90	$4.90
11750	T	Removal of nail bed	161	3.50	$185.12	$75.48	$37.02
11752	T	Remove nail bed/finger tip	163	10.69	$565.14	$264.65	$113.03
11755	T	Biopsy, nail unit	137	0.46	$24.49	$4.90	$4.90
11760	T	Reconstruction of nail bed	181	2.19	$115.58	$43.84	$23.12
11762	T	Reconstruction of nail bed	181	2.19	$115.58	$43.84	$23.12
11765	T	Excision of nail fold, toe	151	1.74	$92.07	$35.71	$18.41
11770	T	Removal of pilonidal lesion	162	5.67	$299.71	$125.43	$59.94
11771	T	Removal of pilonidal lesion	163	10.69	$565.14	$264.65	$113.03
11772	T	Removal of pilonidal lesion	163	10.69	$565.14	$264.65	$113.03
11900	T	Injection into skin lesions	151	1.74	$92.07	$35.71	$18.41
11901	T	Added skin lesions injection	151	1.74	$92.07	$35.71	$18.41
11920	T	Correct skin color defects	181	2.19	$115.58	$43.84	$23.12
11921	T	Correct skin color defects	181	2.19	$115.58	$43.84	$23.12
11922	T	Correct skin color defects	181	2.19	$115.58	$43.84	$23.12
11950	T	Therapy for contour defects	181	2.19	$115.58	$43.84	$23.12
11951	T	Therapy for contour defects	181	2.19	$115.58	$43.84	$23.12
11952	T	Therapy for contour defects	181	2.19	$115.58	$43.84	$23.12
11954	T	Therapy for contour defects	181	2.19	$115.58	$43.84	$23.12
11960	T	Insert tissue expander(s)	183	11.17	$590.61	$286.57	$118.12
11970	T	Replace tissue expander	183	11.17	$590.61	$286.57	$118.12
11971	T	Remove tissue expander(s)	163	10.69	$565.14	$264.65	$113.03
11975	E	Insert contraceptive cap	.....	.....	.....	.....	.....
11976	T	Removal of contraceptive cap	131	1.94	$102.84	$36.61	$20.57
11977	E	Removal/reinsert contra cap	.....	.....	.....	.....	.....
12001	T	Repair superficial wound(s)	181	2.19	$115.58	$43.84	$23.12
12002	T	Repair superficial wound(s)	181	2.19	$115.58	$43.84	$23.12
12004	T	Repair superficial wound(s)	181	2.19	$115.58	$43.84	$23.12
12005	T	Repair superficial wound(s)	181	2.19	$115.58	$43.84	$23.12
12006	T	Repair superficial wound(s)	181	2.19	$115.58	$43.84	$23.12
12007	T	Repair superficial wound(s)	181	2.19	$115.58	$43.84	$23.12

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
12011	T	Repair superficial wound(s)	181	2.19	$115.58	$43.84	$23.12
12013	T	Repair superficial wound(s)	181	2.19	$115.58	$43.84	$23.12
12014	T	Repair superficial wound(s)	181	2.19	$115.58	$43.84	$23.12
12015	T	Repair superficial wound(s)	181	2.19	$115.58	$43.84	$23.12
12016	T	Repair superficial wound(s)	181	2.19	$115.58	$43.84	$23.12
12017	T	Repair superficial wound(s)	181	2.19	$115.58	$43.84	$23.12
12018	T	Repair superficial wound(s)	181	2.19	$115.58	$43.84	$23.12
12020	T	Closure of split wound	181	2.19	$115.58	$43.84	$23.12
12021	T	Closure of split wound	181	2.19	$115.58	$43.84	$23.12
12031	T	Layer closure of wound(s)	181	2.19	$115.58	$43.84	$23.12
12032	T	Layer closure of wound(s)	181	2.19	$115.58	$43.84	$23.12
12034	T	Layer closure of wound(s)	181	2.19	$115.58	$43.84	$23.12
12035	T	Layer closure of wound(s)	181	2.19	$115.58	$43.84	$23.12
12036	T	Layer closure of wound(s)	181	2.19	$115.58	$43.84	$23.12
12037	T	Layer closure of wound(s)	183	11.17	$590.61	$286.57	$118.12
12041	T	Layer closure of wound(s)	181	2.19	$115.58	$43.84	$23.12
12042	T	Layer closure of wound(s)	181	2.19	$115.58	$43.84	$23.12
12044	T	Layer closure of wound(s)	181	2.19	$115.58	$43.84	$23.12
12045	T	Layer closure of wound(s)	181	2.19	$115.58	$43.84	$23.12
12046	T	Layer closure of wound(s)	181	2.19	$115.58	$43.84	$23.12
12047	T	Layer closure of wound(s)	183	11.17	$590.61	$286.57	$118.12
12051	T	Layer closure of wound(s)	181	2.19	$115.58	$43.84	$23.12
12052	T	Layer closure of wound(s)	181	2.19	$115.58	$43.84	$23.12
12053	T	Layer closure of wound(s)	181	2.19	$115.58	$43.84	$23.12
12054	T	Layer closure of wound(s)	181	2.19	$115.58	$43.84	$23.12
12055	T	Layer closure of wound(s)	181	2.19	$115.58	$43.84	$23.12
12056	T	Layer closure of wound(s)	181	2.19	$115.58	$43.84	$23.12
12057	T	Layer closure of wound(s)	183	11.17	$590.61	$286.57	$118.12
13100	T	Repair of wound or lesion	182	4.00	$211.56	$84.98	$42.31
13101	T	Repair of wound or lesion	182	4.00	$211.56	$84.98	$42.31
13120	T	Repair of wound or lesion	182	4.00	$211.56	$84.98	$42.31
13121	T	Repair of wound or lesion	182	4.00	$211.56	$84.98	$42.31
13131	T	Repair of wound or lesion	182	4.00	$211.56	$84.98	$42.31
13132	T	Repair of wound or lesion	182	4.00	$211.56	$84.98	$42.31
13150	T	Repair of wound or lesion	182	4.00	$211.56	$84.98	$42.31
13151	T	Repair of wound or lesion	182	4.00	$211.56	$84.98	$42.31
13152	T	Repair of wound or lesion	182	4.00	$211.56	$84.98	$42.31
13160	T	Late closure of wound	182	4.00	$211.56	$84.98	$42.31
13300	T	Repair of wound or lesion	182	4.00	$211.56	$84.98	$42.31
14000	T	Skin tissue rearrangement	183	11.17	$590.61	$286.57	$118.12
14001	T	Skin tissue rearrangement	183	11.17	$590.61	$286.57	$118.12
14020	T	Skin tissue rearrangement	183	11.17	$590.61	$286.57	$118.12
14021	T	Skin tissue rearrangement	183	11.17	$590.61	$286.57	$118.12
14040	T	Skin tissue rearrangement	183	11.17	$590.61	$286.57	$118.12
14041	T	Skin tissue rearrangement	183	11.17	$590.61	$286.57	$118.12
14060	T	Skin tissue rearrangement	183	11.17	$590.61	$286.57	$118.12
14061	T	Skin tissue rearrangement	183	11.17	$590.61	$286.57	$118.12
14300	T	Skin tissue rearrangement	183	11.17	$590.61	$286.57	$118.12
14350	T	Skin tissue rearrangement	183	11.17	$590.61	$286.57	$118.12
15000	T	Skin graft procedure	183	11.17	$590.61	$286.57	$118.12
15050	T	Skin pinch graft procedure	183	11.17	$590.61	$286.57	$118.12
15100	T	Skin split graft procedure	183	11.17	$590.61	$286.57	$118.12
15101	T	Skin split graft procedure	183	11.17	$590.61	$286.57	$118.12
15120	T	Skin split graft procedure	183	11.17	$590.61	$286.57	$118.12
15121	T	Skin split graft procedure	183	11.17	$590.61	$286.57	$118.12
15200	T	Skin full graft procedure	183	11.17	$590.61	$286.57	$118.12
15201	T	Skin full graft procedure	183	11.17	$590.61	$286.57	$118.12
15220	T	Skin full graft procedure	183	11.17	$590.61	$286.57	$118.12
15221	T	Skin full graft procedure	183	11.17	$590.61	$286.57	$118.12
15240	T	Skin full graft procedure	183	11.17	$590.61	$286.57	$118.12
15241	T	Skin full graft procedure	183	11.17	$590.61	$286.57	$118.12
15260	T	Skin full graft procedure	183	11.17	$590.61	$286.57	$118.12
15261	T	Skin full graft procedure	183	11.17	$590.61	$286.57	$118.12
15350	T	Skin homograft procedure	183	11.17	$590.61	$286.57	$118.12
15400	T	Skin heterograft procedure	183	11.17	$590.61	$286.57	$118.12
15570	T	Form skin pedicle flap	183	11.17	$590.61	$286.57	$118.12
15572	T	Form skin pedicle flap	183	11.17	$590.61	$286.57	$118.12
15574	T	Form skin pedicle flap	183	11.17	$590.61	$286.57	$118.12
15576	T	Form skin pedicle flap	183	11.17	$590.61	$286.57	$118.12
15580	T	Attach skin pedicle graft	183	11.17	$590.61	$286.57	$118.12
15600	T	Skin graft procedure	183	11.17	$590.61	$286.57	$118.12
15610	T	Skin graft procedure	183	11.17	$590.61	$286.57	$118.12
15620	T	Skin graft procedure	183	11.17	$590.61	$286.57	$118.12
15625	T	Skin graft procedure	183	11.17	$590.61	$286.57	$118.12
15630	T	Skin graft procedure	183	11.17	$590.61	$286.57	$118.12

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
15650	T	Transfer skin pedicle flap	183	11.17	$590.61	$286.57	$118.12
15732	T	Muscle-skin graft, head/neck	184	15.17	$802.17	$396.40	$160.43
15734	T	Muscle-skin graft, trunk	184	15.17	$802.17	$396.40	$160.43
15736	T	Muscle-skin graft, arm	184	15.17	$802.17	$396.40	$160.43
15738	T	Muscle-skin graft, leg	184	15.17	$802.17	$396.40	$160.43
15740	T	Island pedicle flap graft	184	15.17	$802.17	$396.40	$160.43
15750	T	Neurovascular pedicle graft	184	15.17	$802.17	$396.40	$160.43
15756	C	Free muscle flap, microvasc	.....	.....	.....	.....	.....
15757	C	Free skin flap, microvasc	.....	.....	.....	.....	.....
15758	C	Free fascial flap, microvasc	.....	.....	.....	.....	.....
15760	T	Composite skin graft	184	15.17	$802.17	$396.40	$160.43
15770	T	Derma-fat-fascia graft	184	15.17	$802.17	$396.40	$160.43
15775	T	Hair transplant punch grafts	183	11.17	$590.61	$286.57	$118.12
15776	T	Hair transplant punch grafts	183	11.17	$590.61	$286.57	$118.12
15780	T	Abrasion treatment of skin	163	10.69	$565.14	$264.65	$113.03
15781	T	Abrasion treatment of skin	163	10.69	$565.14	$264.65	$113.03
15782	T	Abrasion treatment of skin	163	10.69	$565.14	$264.65	$113.03
15783	T	Abrasion treatment of skin	151	1.74	$92.07	$35.71	$18.41
15786	T	Abrasion treatment of lesion	151	1.74	$92.07	$35.71	$18.41
15787	T	Abrasion, added skin lesions	151	1.74	$92.07	$35.71	$18.41
15788	T	Chemical peel, face, epiderm	151	1.74	$92.07	$35.71	$18.41
15789	T	Chemical peel, face, dermal	151	1.74	$92.07	$35.71	$18.41
15792	T	Chemical peel, nonfacial	151	1.74	$92.07	$35.71	$18.41
15793	T	Chemical peel, nonfacial	151	1.74	$92.07	$35.71	$18.41
15810	T	Salabrasion	151	1.74	$92.07	$35.71	$18.41
15811	T	Salabrasion	163	10.69	$565.14	$264.65	$113.03
15819	T	Plastic surgery, neck	183	11.17	$590.61	$286.57	$118.12
15820	T	Revision of lower eyelid	183	11.17	$590.61	$286.57	$118.12
15821	T	Revision of lower eyelid	183	11.17	$590.61	$286.57	$118.12
15822	T	Revision of upper eyelid	183	11.17	$590.61	$286.57	$118.12
15823	T	Revision of upper eyelid	183	11.17	$590.61	$286.57	$118.12
15824	T	Removal of forehead wrinkles	184	15.17	$802.17	$396.40	$160.43
15825	T	Removal of neck wrinkles	183	11.17	$590.61	$286.57	$118.12
15826	T	Removal of brow wrinkles	184	15.17	$802.17	$396.40	$160.43
15828	T	Removal of face wrinkles	184	15.17	$802.17	$396.40	$160.43
15829	T	Removal of skin wrinkles	183	11.17	$590.61	$286.57	$118.12
15831	T	Excise excessive skin tissue	184	15.17	$802.17	$396.40	$160.43
15832	T	Excise excessive skin tissue	184	15.17	$802.17	$396.40	$160.43
15833	T	Excise excessive skin tissue	184	15.17	$802.17	$396.40	$160.43
15834	T	Excise excessive skin tissue	184	15.17	$802.17	$396.40	$160.43
15835	T	Excise excessive skin tissue	183	11.17	$590.61	$286.57	$118.12
15836	T	Excise excessive skin tissue	184	15.17	$802.17	$396.40	$160.43
15837	T	Excise excessive skin tissue	184	15.17	$802.17	$396.40	$160.43
15838	T	Excise excessive skin tissue	163	10.69	$565.14	$264.65	$113.03
15839	T	Excise excessive skin tissue	184	15.17	$802.17	$396.40	$160.43
15840	T	Graft for face nerve palsy	184	15.17	$802.17	$396.40	$160.43
15841	T	Graft for face nerve palsy	184	15.17	$802.17	$396.40	$160.43
15842	T	Graft for face nerve palsy	184	15.17	$802.17	$396.40	$160.43
15845	T	Skin and muscle repair, face	184	15.17	$802.17	$396.40	$160.43
15850	T	Removal of sutures	151	1.74	$92.07	$35.71	$18.41
15851	T	Removal of sutures	151	1.74	$92.07	$35.71	$18.41
15852	T	Dressing change, not for burn	151	1.74	$92.07	$35.71	$18.41
15860	N	Test for blood flow in graft	.....	.....	.....	.....	.....
15876	T	Suction assisted lipectomy	184	15.17	$802.17	$396.40	$160.43
15877	T	Suction assisted lipectomy	184	15.17	$802.17	$396.40	$160.43
15878	T	Suction assisted lipectomy	184	15.17	$802.17	$396.40	$160.43
15879	T	Suction assisted lipectomy	184	15.17	$802.17	$396.40	$160.43
15920	T	Removal of tail bone ulcer	163	10.69	$565.14	$264.65	$113.03
15922	T	Removal of tail bone ulcer	184	15.17	$802.17	$396.40	$160.43
15931	T	Remove sacrum pressure sore	163	10.69	$565.14	$264.65	$113.03
15933	T	Remove sacrum pressure sore	163	10.69	$565.14	$264.65	$113.03
15934	T	Remove sacrum pressure sore	184	15.17	$802.17	$396.40	$160.43
15935	T	Remove sacrum pressure sore	184	15.17	$802.17	$396.40	$160.43
15936	T	Remove sacrum pressure sore	184	15.17	$802.17	$396.40	$160.43
15937	T	Remove sacrum pressure sore	184	15.17	$802.17	$396.40	$160.43
15940	T	Removal of pressure sore	163	10.69	$565.14	$264.65	$113.03
15941	T	Removal of pressure sore	163	10.69	$565.14	$264.65	$113.03
15944	T	Removal of pressure sore	184	15.17	$802.17	$396.40	$160.43
15945	T	Removal of pressure sore	184	15.17	$802.17	$396.40	$160.43
15946	T	Removal of pressure sore	184	15.17	$802.17	$396.40	$160.43
15950	T	Remove thigh pressure sore	163	10.69	$565.14	$264.65	$113.03
15951	T	Remove thigh pressure sore	163	10.69	$565.14	$264.65	$113.03
15952	T	Remove thigh pressure sore	184	15.17	$802.17	$396.40	$160.43
15953	T	Remove thigh pressure sore	184	15.17	$802.17	$396.40	$160.43
15956	T	Remove thigh pressure sore	184	15.17	$802.17	$396.40	$160.43

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
15958	T	Remove thigh pressure sore	184	15.17	$802.17	$396.40	$160.43
15999	T	Removal of pressure sore	163	10.69	$565.14	$264.65	$113.03
16000	T	Initial treatment of burn(s)	151	1.74	$92.07	$35.71	$18.41
16010	T	Treatment of burn(s)	152	10.43	$551.43	$261.71	$110.29
16015	T	Treatment of burn(s)	152	10.43	$551.43	$261.71	$110.29
16020	T	Treatment of burn(s)	151	1.74	$92.07	$35.71	$18.41
16025	T	Treatment of burn(s)	151	1.74	$92.07	$35.71	$18.41
16030	T	Treatment of burn(s)	151	1.74	$92.07	$35.71	$18.41
16035	T	Incision of burn scab	162	5.67	$299.71	$125.43	$59.94
16040	T	Burn wound excision	162	5.67	$299.71	$125.43	$59.94
16041	T	Burn wound excision	162	5.67	$299.71	$125.43	$59.94
16042	T	Burn wound excision	162	5.67	$299.71	$125.43	$59.94
17000	T	Destroy benign/premal lesion	141	0.59	$31.34	$9.49	$6.27
17003	T	Destroy 2–14 lesions	141	0.59	$31.34	$9.49	$6.27
17004	T	Destroy 15 & more lesions	142	3.78	$199.81	$73.00	$39.96
17106	T	Destruction of skin lesions	141	0.59	$31.34	$9.49	$6.27
17107	T	Destruction of skin lesions	142	3.78	$199.81	$73.00	$39.96
17108	T	Destruction of skin lesions	142	3.78	$199.81	$73.00	$39.96
17110	T	Destruct lesion, 1–14	141	0.59	$31.34	$9.49	$6.27
17111	T	Destruct lesion, 15 or more	142	3.78	$199.81	$73.00	$39.96
17250	T	Chemical cautery, tissue	151	1.74	$92.07	$35.71	$18.41
17260	T	Destruction of skin lesions	151	1.74	$92.07	$35.71	$18.41
17261	T	Destruction of skin lesions	151	1.74	$92.07	$35.71	$18.41
17262	T	Destruction of skin lesions	151	1.74	$92.07	$35.71	$18.41
17263	T	Destruction of skin lesions	151	1.74	$92.07	$35.71	$18.41
17264	T	Destruction of skin lesions	151	1.74	$92.07	$35.71	$18.41
17266	T	Destruction of skin lesions	151	1.74	$92.07	$35.71	$18.41
17270	T	Destruction of skin lesions	151	1.74	$92.07	$35.71	$18.41
17271	T	Destruction of skin lesions	151	1.74	$92.07	$35.71	$18.41
17272	T	Destruction of skin lesions	151	1.74	$92.07	$35.71	$18.41
17273	T	Destruction of skin lesions	151	1.74	$92.07	$35.71	$18.41
17274	T	Destruction of skin lesions	151	1.74	$92.07	$35.71	$18.41
17276	T	Destruction of skin lesions	151	1.74	$92.07	$35.71	$18.41
17280	T	Destruction of skin lesions	151	1.74	$92.07	$35.71	$18.41
17281	T	Destruction of skin lesions	151	1.74	$92.07	$35.71	$18.41
17282	T	Destruction of skin lesions	151	1.74	$92.07	$35.71	$18.41
17283	T	Destruction of skin lesions	151	1.74	$92.07	$35.71	$18.41
17284	T	Destruction of skin lesions	151	1.74	$92.07	$35.71	$18.41
17286	T	Destruction of skin lesions	151	1.74	$92.07	$35.71	$18.41
17304	T	Chemosurgery of skin lesion	162	5.67	$299.71	$125.43	$59.94
17305	T	2nd stage chemosurgery	162	5.67	$299.71	$125.43	$59.94
17306	T	3rd stage chemosurgery	162	5.67	$299.71	$125.43	$59.94
17307	T	Followup skin lesion therapy	162	5.67	$299.71	$125.43	$59.94
17310	T	Extensive skin chemosurgery	162	5.67	$299.71	$125.43	$59.94
17340	T	Cryotherapy of skin	151	1.74	$92.07	$35.71	$18.41
17360	T	Skin peel therapy	151	1.74	$92.07	$35.71	$18.41
17380	T	Hair removal by electrolysis	151	1.74	$92.07	$35.71	$18.41
17999	T	Skin tissue procedure	121	0.67	$35.26	$21.02	$7.05
19000	T	Drainage of breast lesion	121	0.67	$35.26	$21.02	$7.05
19001	T	Drain added breast lesion	121	0.67	$35.26	$21.02	$7.05
19020	T	Incision of breast lesion	132	6.04	$319.30	$134.24	$63.86
19030	T	Injection for breast x-ray	347	2.93	$154.75	$62.15	$30.95
19100	T	Biopsy of breast	122	4.87	$257.60	$115.03	$51.52
19101	T	Biopsy of breast	197	12.13	$641.54	$310.75	$128.31
19110	T	Nipple exploration	197	12.13	$641.54	$310.75	$128.31
19112	T	Excise breast duct fistula	197	12.13	$641.54	$310.75	$128.31
19120	T	Removal of breast lesion	197	12.13	$641.54	$310.75	$128.31
19125	T	Excision, breast lesion	197	12.13	$641.54	$310.75	$128.31
19126	T	Excision, add'l breast lesion	197	12.13	$641.54	$310.75	$128.31
19140	T	Removal of breast tissue	197	12.13	$641.54	$310.75	$128.31
19160	T	Removal of breast tissue	198	19.17	$1,013.73	$530.20	$202.75
19162	T	Remove breast tissue, nodes	198	19.17	$1,013.73	$530.20	$202.75
19180	T	Removal of breast	198	19.17	$1,013.73	$530.20	$202.75
19182	T	Removal of breast	198	19.17	$1,013.73	$530.20	$202.75
19200	C	Removal of breast	.....	.....	.....	.....	.....
19220	C	Removal of breast	.....	.....	.....	.....	.....
19240	C	Removal of breast	.....	.....	.....	.....	.....
19260	C	Removal of chest wall lesion	.....	.....	.....	.....	.....
19271	C	Revision of chest wall	.....	.....	.....	.....	.....
19272	C	Extensive chest wall surgery	.....	.....	.....	.....	.....
19290	T	Place needle wire, breast	197	12.13	$641.54	$310.75	$128.31
19291	T	Place needle wire, breast	197	12.13	$641.54	$310.75	$128.31
19316	T	Suspension of breast	198	19.17	$1,013.73	$530.20	$202.75
19318	T	Reduction of large breast	198	19.17	$1,013.73	$530.20	$202.75
19324	T	Enlarge breast	198	19.17	$1,013.73	$530.20	$202.75

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
19325	T	Enlarge breast with implant	198	19.17	$1,013.73	$530.20	$202.75
19328	T	Removal of breast implant	198	19.17	$1,013.73	$530.20	$202.75
19330	T	Removal of implant material	198	19.17	$1,013.73	$530.20	$202.75
19340	T	Immediate breast prosthesis	198	19.17	$1,013.73	$530.20	$202.75
19342	T	Delayed breast prosthesis	198	19.17	$1,013.73	$530.20	$202.75
19350	T	Breast reconstruction	198	19.17	$1,013.73	$530.20	$202.75
19355	T	Correct inverted nipple(s)	198	19.17	$1,013.73	$530.20	$202.75
19357	T	Breast reconstruction	198	19.17	$1,013.73	$530.20	$202.75
19361	C	Breast reconstruction					
19364	C	Breast reconstruction					
19366	T	Breast reconstruction	198	19.17	$1,013.73	$530.20	$202.75
19367	C	Breast reconstruction					
19368	C	Breast reconstruction					
19369	C	Breast reconstruction					
19370	T	Surgery of breast capsule	198	19.17	$1,013.73	$530.20	$202.75
19371	T	Removal of breast capsule	198	19.17	$1,013.73	$530.20	$202.75
19380	T	Revise breast reconstruction	198	19.17	$1,013.73	$530.20	$202.75
19396	T	Design custom breast implant	197	12.13	$641.54	$310.75	$128.31
19499	T	Breast surgery procedure	197	12.13	$641.54	$310.75	$128.31
20000	T	Incision of abscess	131	1.94	$102.84	$36.61	$20.57
20005	T	Incision of deep abscess	251	14.26	$754.18	$366.12	$150.84
20100	C	Explore wound, neck					
20101	C	Explore wound, chest					
20102	C	Explore wound, abdomen					
20103	C	Explore wound, extremity					
20150	C	Excise epiphyseal bar					
20200	T	Muscle biopsy	162	5.67	$299.71	$125.43	$59.94
20205	T	Deep muscle biopsy	162	5.67	$299.71	$125.43	$59.94
20206	T	Needle biopsy, muscle	122	4.87	$257.6	$115.03	$51.52
20220	T	Bone biopsy, trocar/needle	162	5.67	$299.71	$125.43	$59.94
20225	T	Bone biopsy, trocar/needle	162	5.67	$299.71	$125.43	$59.94
20240	T	Bone biopsy, excisional	163	10.69	$565.14	$264.65	$113.03
20245	T	Bone biopsy, excisional	163	10.69	$565.14	$264.65	$113.03
20250	T	Open bone biopsy	251	14.26	$754.18	$366.12	$150.84
20251	T	Open bone biopsy	251	14.26	$754.18	$366.12	$150.84
20500	T	Injection of sinus tract	181	2.19	$115.58	$43.84	$23.12
20501	T	Inject sinus tract for x-ray	347	2.93	$154.75	$62.15	$30.95
20520	T	Removal of foreign body	161	3.50	$185.12	$75.48	$37.02
20525	T	Removal of foreign body	163	10.69	$565.14	$264.65	$113.03
20550	T	Inj tendon/ligament/cyst	200	1.89	$99.90	$39.10	$19.98
20600	T	Drain/inject joint/bursa	200	1.89	$99.90	$39.10	$19.98
20605	T	Drain/inject joint/bursa	200	1.89	$99.90	$39.10	$19.98
20610	T	Drain/inject joint/bursa	200	1.89	$99.90	$39.10	$19.98
20615	T	Treatment of bone cyst	121	0.67	$35.26	$21.02	$7.05
20650	T	Insert and remove bone pin	251	14.26	$754.18	$366.12	$150.84
20660	C	Apply,remove fixation device					
20661	C	Application of head brace					
20662	C	Application of pelvis brace					
20663	C	Application of thigh brace					
20664	C	Halo brace application					
20665	N	Removal of fixation device					
20670	T	Removal of support implant	162	5.67	$299.71	$125.43	$59.94
20680	T	Removal of support implant	163	10.69	$565.14	$264.65	$113.03
20690	T	Apply bone fixation device	252	19.39	$1,025.49	$509.18	$205.10
20692	T	Apply bone fixation device	252	19.39	$1,025.49	$509.18	$205.10
20693	T	Adjust bone fixation device	251	14.26	$754.18	$366.12	$150.84
20694	T	Remove bone fixation device	251	14.26	$754.18	$366.12	$150.84
20802	C	Replantation, arm, complete					
20805	C	Replant forearm, complete					
20808	C	Replantation, hand, complete					
20816	C	Replantation digit, complete					
20822	C	Replantation digit, complete					
20824	C	Replantation thumb, complete					
20827	C	Replantation thumb, complete					
20838	C	Replantation, foot, complete					
20900	T	Removal of bone for graft	252	19.39	$1,025.49	$509.18	$205.10
20902	T	Removal of bone for graft	252	19.39	$1,025.49	$509.18	$205.10
20910	T	Remove cartilage for graft	183	11.17	$590.61	$286.57	$118.12
20912	T	Remove cartilage for graft	183	11.17	$590.61	$286.57	$118.12
20920	T	Removal of fascia for graft	183	11.17	$590.61	$286.57	$118.12
20922	T	Removal of fascia for graft	183	11.17	$590.61	$286.57	$118.12
20924	T	Removal of tendon for graft	252	19.39	$1,025.49	$509.18	$205.10
20926	T	Removal of tissue for graft	183	11.17	$590.61	$286.57	$118.12
20930	C	Spinal bone allograft					
20931	C	Spinal bone allograft					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
20936	C	Spinal bone autograft	.....	.....	.....	.....	.....
20937	C	Spinal bone autograft	.....	.....	.....	.....	.....
20938	C	Spinal bone autograft	.....	.....	.....	.....	.....
20950	T	Record fluid pressure,muscle	132	6.04	$319.30	$134.24	$63.86
20955	C	Fibula bone graft, microvasc	.....	.....	.....	.....	.....
20956	C	Iliac bone graft, microvasc	.....	.....	.....	.....	.....
20957	C	Mt bone graft, microvasc	.....	.....	.....	.....	.....
20962	C	Other bone graft, microvasc	.....	.....	.....	.....	.....
20969	C	Bone/skin graft, microvasc	.....	.....	.....	.....	.....
20970	C	Bone/skin graft, iliac crest	.....	.....	.....	.....	.....
20972	C	Bone-skin graft, metatarsal	.....	.....	.....	.....	.....
20973	C	Bone-skin graft, great toe	.....	.....	.....	.....	.....
20974	A	Electrical bone stimulation	.....	.....	.....	.....	.....
20975	T	Electrical bone stimulation	251	14.26	$754.18	$366.12	$150.84
20999	N	Musculoskeletal surgery	.....	.....	.....	.....	.....
21010	T	Incision of jaw joint	232	23.93	$1,265.45	$639.35	$253.09
21015	T	Resection of facial tumor	231	12.02	$635.66	299.90	$127.13
21025	T	Excision of bone, lower jaw	231	12.02	$635.66	299.90	$127.13
21026	T	Excision of facial bone(s)	231	12.02	$635.66	299.90	$127.13
21029	T	Contour of face bone lesion	231	12.02	$635.66	299.90	$127.13
21030	T	Removal of face bone lesion	231	12.02	$635.66	299.90	$127.13
21031	T	Remove exostosis, mandible	231	12.02	$635.66	299.90	$127.13
21032	T	Remove exostosis, maxilla	231	12.02	$635.66	299.90	$127.13
21034	T	Removal of face bone lesion	232	23.93	$1,265.45	$639.35	$253.09
21040	T	Removal of jaw bone lesion	231	12.02	$635.66	299.90	$127.13
21041	T	Removal of jaw bone lesion	231	12.02	$635.66	299.90	$127.13
21044	T	Removal of jaw bone lesion	232	23.93	$1,265.45	$639.35	$253.09
21045	C	Extensive jaw surgery	.....	.....	.....	.....	.....
21050	T	Removal of jaw joint	232	23.93	$1,265.45	$639.35	$253.09
21060	T	Remove jaw joint cartilage	232	23.93	$1,265.45	$639.35	$253.09
21070	T	Remove coronoid process	232	23.93	$1,265.45	$639.35	$253.09
21076	T	Prepare face/oral prosthesis	226	1.59	$84.23	$21.92	$16.85
21077	T	Prepare face/oral prosthesis	226	1.59	$84.23	$21.92	$16.85
21079	T	Prepare face/oral prosthesis	226	1.59	$84.23	$21.92	$16.85
21080	T	Prepare face/oral prosthesis	226	1.59	$84.23	$21.92	$16.85
21081	T	Prepare face/oral prosthesis	226	1.59	$84.23	$21.92	$16.85
21082	T	Prepare face/oral prosthesis	226	1.59	$84.23	$21.92	$16.85
21083	T	Prepare face/oral prosthesis	226	1.59	$84.23	$21.92	$16.85
21084	T	Prepare face/oral prosthesis	226	1.59	$84.23	$21.92	$16.85
21085	N	Prepare face/oral prosthesis	.....	.....	.....	.....	.....
21086	T	Prepare face/oral prosthesis	226	1.59	$84.23	$21.92	$16.85
21087	T	Prepare face/oral prosthesis	226	1.59	$84.23	$21.92	$16.85
21088	T	Prepare face/oral prosthesis	226	1.59	$84.23	$21.92	$16.85
21089	T	Prepare face/oral prosthesis	226	1.59	$84.23	$21.92	$16.85
21100	T	Maxillofacial fixation	231	12.02	$635.66	299.90	$127.13
21110	T	Interdental fixation	231	12.02	$635.66	299.90	$127.13
21116	T	Injection, jaw joint x-ray	347	2.93	$154.75	$62.15	$30.95
21120	T	Reconstruction of chin	231	12.02	$635.66	299.90	$127.13
21121	T	Reconstruction of chin	232	23.93	$1,265.45	$639.35	$253.09
21122	T	Reconstruction of chin	232	23.93	$1,265.45	$639.35	$253.09
21123	T	Reconstruction of chin	232	23.93	$1,265.45	$639.35	$253.09
21125	T	Augmentation lower jaw bone	231	12.02	$635.66	299.90	$127.13
21127	T	Augmentation lower jaw bone	232	23.93	$1,265.45	$639.35	$253.09
21137	C	Reduction of forehead	.....	.....	.....	.....	.....
21138	C	Reduction of forehead	.....	.....	.....	.....	.....
21139	C	Reduction of forehead	.....	.....	.....	.....	.....
21141	C	Reconstruct midface, lefort	.....	.....	.....	.....	.....
21142	C	Reconstruct midface, lefort	.....	.....	.....	.....	.....
21143	C	Reconstruct midface, lefort	.....	.....	.....	.....	.....
21145	C	Reconstruct midface, lefort	.....	.....	.....	.....	.....
21146	C	Reconstruct midface, lefort	.....	.....	.....	.....	.....
21147	C	Reconstruct midface, lefort	.....	.....	.....	.....	.....
21150	C	Reconstruct midface, lefort	.....	.....	.....	.....	.....
21151	C	Reconstruct midface, lefort	.....	.....	.....	.....	.....
21154	C	Reconstruct midface, lefort	.....	.....	.....	.....	.....
21155	C	Reconstruct midface, lefort	.....	.....	.....	.....	.....
21159	C	Reconstruct midface, lefort	.....	.....	.....	.....	.....
21160	C	Reconstruct midface, lefort	.....	.....	.....	.....	.....
21172	C	Reconstruct orbit/forehead	.....	.....	.....	.....	.....
21175	C	Reconstruct orbit/forehead	.....	.....	.....	.....	.....
21179	C	Reconstruct entire forehead	.....	.....	.....	.....	.....
21180	C	Reconstruct entire forehead	.....	.....	.....	.....	.....
21181	T	Contour cranial bone lesion	232	23.93	$1,265.45	$639.35	$253.09
21182	C	Reconstruct cranial bone	.....	.....	.....	.....	.....
21183	C	Reconstruct cranial bone	.....	.....	.....	.....	.....

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
21184	C	Reconstruct cranial bone					
21188	C	Reconstruction of midface					
21193	C	Reconstruct lower jaw bone					
21194	C	Reconstruct lower jaw bone					
21195	C	Reconstruct lower jaw bone					
21196	C	Reconstruct lower jaw bone					
21198	C	Reconstruct lower jaw bone					
21206	T	Reconstruct upper jaw bone	232	23.93	$1,265.45	$639.35	$253.09
21208	T	Augmentation of facial bones	232	23.93	$1,265.45	$639.35	$253.09
21209	T	Reduction of facial bones	232	23.93	$1,265.45	$639.35	$253.09
21210	T	Face bone graft	232	23.93	$1,265.45	$639.35	$253.09
21215	T	Lower jaw bone graft	232	23.93	$1,265.45	$639.35	$253.09
21230	T	Rib cartilage graft	232	23.93	$1,265.45	$639.35	$253.09
21235	T	Ear cartilage graft	232	23.93	$1,265.45	$639.35	$253.09
21240	T	Reconstruction of jaw joint	232	23.93	$1,265.45	$639.35	$253.09
21242	T	Reconstruction of jaw joint	232	23.93	$1,265.45	$639.35	$253.09
21243	T	Reconstruction of jaw joint	218	27.50	$1,454.49	$715.52	$290.90
21244	T	Reconstruction of lower jaw	232	23.93	$1,265.45	$639.35	$253.09
21245	T	Reconstruction of jaw	232	23.93	$1,265.45	$639.35	$253.09
21246	T	Reconstruction of jaw	232	23.93	$1,265.45	$639.35	$253.09
21247	C	Reconstruct lower jaw bone					
21248	T	Reconstruction of jaw	232	23.93	$1,265.45	$639.35	$253.09
21249	T	Reconstruction of jaw	232	23.93	$1,265.45	$639.35	$253.09
21255	C	Reconstruct lower jaw bone					
21256	C	Reconstruction of orbit					
21260	T	Revise eye sockets	232	23.93	$1,265.45	$639.35	$253.09
21261	C	Revise eye sockets					
21263	C	Revise eye sockets					
21267	T	Revise eye sockets	232	23.93	$1,265.45	$639.35	$253.09
21268	C	Revise eye sockets					
21270	T	Augmentation cheek bone	232	23.93	$1,265.45	$639.35	$253.09
21275	T	Revision orbitofacial bones	232	23.93	$1,265.45	$639.35	$253.09
21280	T	Revision of eyelid	231	12.02	$635.66	$299.90	$127.13
21282	T	Revision of eyelid	231	12.02	$635.66	$299.90	$127.13
21295	T	Revision of jaw muscle/bone	231	12.02	$635.66	$299.90	$127.13
21296	T	Revision of jaw muscle/bone	231	12.02	$635.66	$299.90	$127.13
21299	T	Cranio/maxillofacial surgery	231	12.02	$635.66	$299.90	$127.13
21300	T	Treatment of skull fracture	231	12.02	$635.66	$299.90	$127.13
21310	T	Treatment of nose fracture	231	12.02	$635.66	$299.90	$127.13
21315	T	Treatment of nose fracture	231	12.02	$635.66	$299.90	$127.13
21320	T	Treatment of nose fracture	231	12.02	$635.66	$299.90	$127.13
21325	T	Repair of nose fracture	231	12.02	$635.66	$299.90	$127.13
21330	T	Repair of nose fracture	232	23.93	$1,265.45	$639.35	$253.09
21335	T	Repair of nose fracture	232	23.93	$1,265.45	$639.35	$253.09
21336	T	Repair nasal septal fracture	216	20.13	$1,064.67	$520.93	$212.93
21337	T	Repair nasal septal fracture	231	12.02	$635.66	$299.90	$127.13
21338	T	Repair nasoethmoid fracture	232	23.93	$1,265.45	$639.35	$253.09
21339	T	Repair nasoethmoid fracture	232	23.93	$1,265.45	$639.35	$253.09
21340	T	Repair of nose fracture	232	23.93	$1,265.45	$639.35	$253.09
21343	T	Repair of sinus fracture	232	23.93	$1,265.45	$639.35	$253.09
21344	C	Repair of sinus fracture					
21345	T	Repair of nose/jaw fracture	232	23.93	$1,265.45	$639.35	$253.09
21346	C	Repair of nose/jaw fracture					
21347	C	Repair of nose/jaw fracture					
21348	C	Repair of nose/jaw fracture					
21355	T	Repair cheek bone fracture	231	12.02	$635.66	$299.90	$127.13
21356	C	Repair cheek bone fracture					
21360	C	Repair cheek bone fracture					
21365	C	Repair cheek bone fracture					
21366	C	Repair cheek bone fracture					
21385	C	Repair eye socket fracture					
21386	C	Repair eye socket fracture					
21387	C	Repair eye socket fracture					
21390	C	Repair eye socket fracture					
21395	C	Repair eye socket fracture					
21400	T	Treat eye socket fracture	231	12.02	$635.66	$299.90	$127.13
21401	T	Repair eye socket fracture	231	12.02	$635.66	$299.90	$127.13
21406	C	Repair eye socket fracture					
21407	C	Repair eye socket fracture					
21408	C	Repair eye socket fracture					
21421	T	Treat mouth roof fracture	232	23.93	$1,265.45	$639.35	$253.09
21422	C	Repair mouth roof fracture					
21423	C	Repair mouth roof fracture					
21431	C	Treat craniofacial fracture					
21432	C	Repair craniofacial fracture					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
21433	C	Repair craniofacial fracture					
21435	C	Repair craniofacial fracture					
21436	C	Repair craniofacial fracture					
21440	T	Repair dental ridge fracture	231	12.02	$635.66	$299.90	$127.13
21445	T	Repair dental ridge fracture	232	23.93	$1,265.45	$639.35	$253.09
21450	T	Treat lower jaw fracture	232	23.93	$1,265.45	$639.35	$253.09
21451	T	Treat lower jaw fracture	231	12.02	$635.66	$299.90	$127.13
21452	T	Treat lower jaw fracture	232	23.93	$1,265.45	$639.35	$253.09
21453	T	Treat lower jaw fracture	232	23.93	$1,265.45	$639.35	$253.09
21454	T	Treat lower jaw fracture	232	23.93	$1,265.45	$639.35	$253.09
21461	T	Repair lower jaw fracture	232	23.93	$1,265.45	$639.35	$253.09
21462	T	Repair lower jaw fracture	232	23.93	$1,265.45	$639.35	$253.09
21465	T	Repair lower jaw fracture	232	23.93	$1,265.45	$639.35	$253.09
21470	C	Repair lower jaw fracture					
21480	T	Reset dislocated jaw	231	12.02	$635.66	$299.90	$127.13
21485	T	Reset dislocated jaw	231	12.02	$635.66	$299.90	$127.13
21490	T	Repair dislocated jaw	232	23.93	$1,265.45	$639.35	$253.09
21493	T	Treat hyoid bone fracture	231	12.02	$635.66	$299.90	$127.13
21494	T	Repair hyoid bone fracture	231	12.02	$635.66	$299.90	$127.13
21495	C	Repair hyoid bone fracture					
21497	T	Interdental wiring	231	12.02	$635.66	$299.90	$127.13
21499	T	Head surgery procedure	231	12.02	$635.66	$299.90	$127.13
21501	T	Drain neck/chest lesion	132	6.04	$319.30	$134.24	$63.86
21502	T	Drain chest lesion	252	19.39	$1,025.49	$509.18	$205.10
21510	C	Drainage of bone lesion					
21550	T	Biopsy of neck/chest	161	3.50	$185.12	$75.48	$37.02
21555	T	Remove lesion neck/chest	163	10.69	$565.14	$264.65	$113.03
21556	T	Remove lesion neck/chest	163	10.69	$565.14	$264.65	$113.03
21557	C	Remove tumor, neck or chest					
21600	T	Partial removal of rib	252	19.39	$1,025.49	$509.18	$205.10
21610	T	Partial removal of rib	252	19.39	$1,025.49	$509.18	$205.10
21615	C	Removal of rib					
21616	C	Removal of rib and nerves					
21620	C	Partial removal of sternum					
21627	C	Sternal debridement					
21630	C	Extensive sternum surgery					
21632	C	Extensive sternum surgery					
21700	T	Revision of neck muscle	132	6.04	$319.30	$134.24	$63.86
21705	C	Revision of neck muscle/rib					
21720	T	Revision of neck muscle	132	6.04	$319.30	$134.24	$63.86
21725	T	Revision of neck muscle	132	6.04	$319.30	$134.24	$63.86
21740	C	Reconstruction of sternum					
21750	C	Repair of sternum separation					
21800	T	Treatment of rib fracture	207	1.70	$90.11	$31.64	$18.02
21805	T	Treatment of rib fracture	216	20.13	$1,064.67	$520.93	$212.93
21810	C	Treatment of rib fracture(s)					
21820	T	Treat sternum fracture	207	1.70	$90.11	$31.64	$18.02
21825	C	Repair sternum fracture					
21899	T	Neck/chest surgery procedure	207	1.70	$90.11	$31.64	$18.02
21920	T	Biopsy soft tissue of back	161	3.50	$185.12	$75.48	$37.02
21925	T	Biopsy soft tissue of back	163	10.69	$565.14	$264.65	$113.03
21930	T	Remove lesion, back or flank	163	10.69	$565.14	$264.65	$113.03
21935	T	Remove tumor of back	163	10.69	$565.14	$264.65	$113.03
22100	C	Remove part of neck vertebra					
22101	C	Remove part, thorax vertebra					
22102	C	Remove part, lumbar vertebra					
22103	C	Remove extra spine segment					
22110	C	Remove part of neck vertebra					
22112	C	Remove part, thorax vertebra					
22114	C	Remove part, lumbar vertebra					
22116	C	Remove extra spine segment					
22210	C	Revision of neck spine					
22212	C	Revision of thorax spine					
22214	C	Revision of lumbar spine					
22216	C	Revise, extra spine segment					
22220	C	Revision of neck spine					
22222	C	Revision of thorax spine					
22224	C	Revision of lumbar spine					
22226	C	Revise, extra spine segment					
22305	T	Treat spine process fracture	207	1.70	$90.11	$31.64	$18.02
22310	T	Treat spine fracture	207	1.70	$90.11	$31.64	$18.02
22315	T	Treat spine fracture	207	1.70	$90.11	$31.64	$18.02
22325	C	Repair of spine fracture					
22326	C	Repair neck spine fracture					
22327	C	Repair thorax spine fracture					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
22328	C	Repair each add spine fx					
22505	T	Manipulation of spine	210	10.46	$553.39	$283.4	$110.68
22548	C	Neck spine fusion					
22554	C	Neck spine fusion					
22556	C	Thorax spine fusion					
22558	C	Lumbar spine fusion					
22585	C	Additional spinal fusion					
22590	C	Spine & skull spinal fusion					
22595	C	Neck spinal fusion					
22600	C	Neck spine fusion					
22610	C	Thorax spine fusion					
22612	C	Lumbar spine fusion					
22614	C	Spine fusion, extra segment					
22630	C	Lumbar spine fusion					
22632	C	Spine fusion, extra segment					
22800	C	Fusion of spine					
22802	C	Fusion of spine					
22804	C	Fusion of spine					
22808	C	Fusion of spine					
22810	C	Fusion of spine					
22812	C	Fusion of spine					
22818	C	Kyphectomy, 1–2 segments					
22819	C	Kyphectomy, 3 & more segment					
22830	C	Exploration of spinal fusion					
22840	C	Insert spine fixation device					
22841	C	Insert spine fixation device					
22842	C	Insert spine fixation device					
22843	C	Insert spine fixation device					
22844	C	Insert spine fixation device					
22845	C	Insert spine fixation device					
22846	C	Insert spine fixation device					
22847	C	Insert spine fixation device					
22848	C	Insert pelvic fixation device					
22849	C	Reinsert spinal fixation					
22850	C	Remove spine fixation device					
22851	C	Apply spine prosth device					
22852	C	Remove spine fixation device					
22855	C	Remove spine fixation device					
22899	T	Spine surgery procedure	207	1.70	$90.11	$31.64	$18.02
22900	T	Remove abdominal wall lesion	163	10.69	$565.14	$264.65	$113.03
22999	T	Abdomen surgery procedure	163	10.69	$565.14	$264.65	$113.03
23000	T	Removal of calcium deposits	162	5.67	$299.71	$125.43	$59.94
23020	T	Release shoulder joint	253	26.33	$1,392.78	$699.24	$278.56
23030	T	Drain shoulder lesion	132	6.04	$319.30	$134.24	$63.86
23031	T	Drain shoulder bursa	132	6.04	$319.30	$134.24	$63.86
23035	C	Drain shoulderbone lesion					
23040	T	Exploratory shoulder surgery	252	19.39	$1,025.49	$509.18	$205.10
23044	T	Exploratory shoulder surgery	252	19.39	$1,025.49	$509.18	$205.10
23065	T	Biopsy shoulder tissues	161	3.50	$185.12	$75.48	$37.02
23066	T	Biopsy shoulder tissues	163	10.69	$565.14	$264.65	$113.03
23075	T	Removal of shoulder lesion	162	5.67	$299.71	$125.43	$59.94
23076	T	Removal of shoulder lesion	163	10.69	$565.14	$264.65	$113.03
23077	T	Remove tumor of shoulder	163	10.69	$565.14	$264.65	$113.03
23100	T	Biopsy of shoulder joint	251	14.26	$754.18	$366.12	$150.84
23101	T	Shoulder joint surgery	252	19.39	$1,025.49	$509.18	$205.10
23105	T	Remove shoulder joint lining	252	19.39	$1,025.49	$509.18	$205.10
23106	T	Incision of collarbone joint	252	19.39	$1,025.49	$509.18	$205.10
23107	T	Explore, treat shoulder joint	252	19.39	$1,025.49	$509.18	$205.10
23120	T	Partial removal, collarbone	253	26.33	$1,392.78	$699.24	$278.56
23125	C	Removal of collarbone					
23130	T	Partial removal, shoulderbone	253	26.33	$1,392.78	$699.24	$278.56
23140	T	Removal of bone lesion	251	14.26	$754.18	$366.12	$150.84
23145	T	Removal of bone lesion	252	19.39	$1,025.49	$509.18	$205.10
23146	T	Removal of bone lesion	252	19.39	$1,025.49	$509.18	$205.10
23150	T	Removal of humerus lesion	252	19.39	$1,025.49	$509.18	$205.10
23155	T	Removal of humerus lesion	252	19.39	$1,025.49	$509.18	$205.10
23156	T	Removal of humerus lesion	252	19.39	$1,025.49	$509.18	$205.10
23170	T	Remove collarbone lesion	252	19.39	$1,025.49	$509.18	$205.10
23172	T	Remove shoulder blade lesion	252	19.39	$1,025.49	$509.18	$205.10
23174	T	Remove humerus lesion	252	19.39	$1,025.49	$509.18	$205.10
23180	T	Remove collarbone lesion	252	19.39	$1,025.49	$509.18	$205.10
23182	T	Remove shoulderblade lesion	252	19.39	$1,025.49	$509.18	$205.10
23184	T	Remove humerus lesion	252	19.39	$1,025.49	$509.18	$205.10
23190	T	Partial removal of scapula	252	19.39	$1,025.49	$509.18	$205.10
23195	C	Removal of head of humerus					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
23200	C	Removal of collarbone	.....	.....	.....	.....	.....
23210	C	Removal of shoulderblade	.....	.....	.....	.....	.....
23220	C	Partial removal of humerus	.....	.....	.....	.....	.....
23221	C	Partial removal of humerus	.....	.....	.....	.....	.....
23222	C	Partial removal of humerus	.....	.....	.....	.....	.....
23330	T	Remove shoulder foreign body	163	10.69	$565.14	$264.65	$113.03
23331	T	Remove shoulder foreign body	163	10.69	$565.14	$264.65	$113.03
23332	C	Remove shoulder foreign body	.....	.....	.....	.....	.....
23350	T	Injection for shoulder x-ray	347	2.93	$154.75	$62.15	$30.95
23395	C	Muscle transfer, shoulder/arm	.....	.....	.....	.....	.....
23397	C	Muscle transfers	.....	.....	.....	.....	.....
23400	C	Fixation of shoulderblade	.....	.....	.....	.....	.....
23405	T	Incision of tendon & muscle	252	19.39	$1,025.49	$509.18	$205.10
23406	T	Incise tendon(s) & muscle(s)	252	19.39	$1,025.49	$509.18	$205.10
23410	T	Repair of tendon(s)	254	34.37	$1,817.86	$937.22	$363.57
23412	T	Repair of tendon(s)	254	34.37	$1,817.86	$937.22	$363.57
23415	T	Release of shoulder ligament	253	26.33	$1,392.78	$699.24	$278.56
23420	T	Repair of shoulder	254	34.37	$1,817.86	$937.22	$363.57
23430	T	Repair biceps tendon	254	34.37	$1,817.86	$937.22	$363.57
23440	C	Removal/transplant tendon	.....	.....	.....	.....	.....
23450	T	Repair shoulder capsule	254	34.37	$1,817.86	$937.22	$363.57
23455	T	Repair shoulder capsule	254	34.37	$1,817.86	$937.22	$363.57
23460	T	Repair shoulder capsule	254	34.37	$1,817.86	$937.22	$363.57
23462	T	Repair shoulder capsule	254	34.37	$1,817.86	$937.22	$363.57
23465	T	Repair shoulder capsule	254	34.37	$1,817.86	$937.22	$363.57
23466	T	Repair shoulder capsule	254	34.37	$1,817.86	$937.22	$363.57
23470	C	Reconstruct shoulder joint	.....	.....	.....	.....	.....
23472	C	Reconstruct shoulder joint	.....	.....	.....	.....	.....
23480	T	Revision of collarbone	253	26.33	$1,392.78	$699.24	$278.56
23485	T	Revision of collarbone	253	26.33	$1,392.78	$699.24	$278.56
23490	T	Reinforce clavicle	253	26.33	$1,392.78	$699.24	$278.56
23491	T	Reinforce shoulderbones	253	26.33	$1,392.78	$699.24	$278.56
23500	T	Treat clavicle fracture	207	1.70	$90.11	$31.64	$18.02
23505	T	Treat clavicle fracture	207	1.70	$90.11	$31.64	$18.02
23515	T	Repair clavicle fracture	216	20.13	$1,064.67	$520.93	$212.93
23520	T	Treat clavicle dislocation	207	1.70	$90.11	$31.64	$18.02
23525	T	Treat clavicle dislocation	207	1.70	$90.11	$31.64	$18.02
23530	T	Repair clavicle dislocation	216	20.13	$1,064.67	$520.93	$212.93
23532	T	Repair clavicle dislocation	216	20.13	$1,064.67	$520.93	$212.93
23540	T	Treat clavicle dislocation	207	1.70	$90.11	$31.64	$18.02
23545	T	Treat clavicle dislocation	207	1.70	$90.11	$31.64	$18.02
23550	T	Repair clavicle dislocation	216	20.13	$1,064.67	$520.93	$212.93
23552	T	Repair clavicle dislocation	216	20.13	$1,064.67	$520.93	$212.93
23570	T	Treat shoulderblade fracture	207	1.70	$90.11	$31.64	$18.02
23575	T	Treat shoulderblade fracture	207	1.70	$90.11	$31.64	$18.02
23585	T	Repair scapula fracture	216	20.13	$1,064.67	$520.93	$212.93
23600	T	Treat humerus fracture	209	1.94	$102.84	$37.29	$20.57
23605	T	Treat humerus fracture	209	1.94	$102.84	$37.29	$20.57
23615	T	Repair humerus fracture	216	20.13	$1,064.67	$520.93	$212.93
23616	T	Repair humerus fracture	216	20.13	$1,064.67	$520.93	$212.93
23620	T	Treat humerus fracture	209	1.94	$102.84	$37.29	$20.57
23625	T	Treat humerus fracture	209	1.94	$102.84	$37.29	$20.57
23630	T	Repair humerus fracture	216	20.13	$1,064.67	$520.93	$212.93
23650	T	Treat shoulder dislocation	207	1.70	$90.11	$31.64	$18.02
23655	T	Treat shoulder dislocation	210	10.46	$553.39	$283.40	$110.68
23660	T	Repair shoulder dislocation	216	20.13	$1,064.67	$520.93	$212.93
23665	T	Treat dislocation/fracture	209	1.94	$102.84	$37.29	$20.57
23670	T	Repair dislocation/fracture	216	20.13	$1,064.67	$520.93	$212.93
23675	T	Treat dislocation/fracture	209	1.94	$102.84	$37.29	$20.57
23680	T	Repair dislocation/fracture	216	20.13	$1,064.67	$520.93	$212.93
23700	T	Fixation of shoulder	210	10.46	$553.39	$283.40	$110.68
23800	T	Fusion of shoulder joint	253	26.33	$1,392.78	$699.24	$278.56
23802	T	Fusion of shoulder joint	253	26.33	$1,392.78	$699.24	$278.56
23900	C	Amputation of arm & girdle	.....	.....	.....	.....	.....
23920	C	Amputation at shoulder joint	.....	.....	.....	.....	.....
23921	T	Amputation follow-up surgery	183	11.17	$590.61	$286.57	$118.12
23929	T	Shoulder surgery procedure	207	1.70	$90.11	$31.64	$18.02
23930	T	Drainage of arm lesion	132	6.04	$319.30	$134.24	$63.86
23931	T	Drainage of arm bursa	132	6.04	$319.30	$134.24	$63.86
23935	T	Drain arm/elbow bone lesion	251	14.26	$754.18	$366.12	$150.84
24000	T	Exploratory elbow surgery	252	19.39	$1,025.49	$509.18	$205.10
24006	T	Release elbow joint	252	19.39	$1,025.49	$509.18	$205.10
24065	T	Biopsy arm/elbow soft tissue	161	3.50	$185.12	$75.48	$37.02
24066	T	Biopsy arm/elbow soft tissue	163	10.69	$565.14	$264.65	$113.03
24075	T	Remove arm/elbow lesion	162	5.67	$299.71	$125.43	$59.94

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
24076	T	Remove arm/elbow lesion	163	10.69	$565.14	$264.65	$113.03
24077	T	Remove tumor of arm/elbow	163	10.69	$565.14	$264.65	$113.03
24100	T	Biopsy elbow joint lining	251	14.26	$754.18	$366.12	$150.84
24101	T	Explore/treat elbow joint	252	19.39	$1,025.49	$509.18	$205.10
24102	T	Remove elbow joint lining	252	19.39	$1,025.49	$509.18	$205.10
24105	T	Removal of elbow bursa	251	14.26	$754.18	$366.12	$150.84
24110	T	Remove humerus lesion	251	14.26	$754.18	$366.12	$150.84
24115	T	Remove/graft bone lesion	252	19.39	$1,025.49	$509.18	$205.10
24116	T	Remove/graft bone lesion	252	19.39	$1,025.49	$509.18	$205.10
24120	T	Remove elbow lesion	251	14.26	$754.18	$366.12	$150.84
24125	T	Remove/graft bone lesion	252	19.39	$1,025.49	$509.18	$205.10
24126	T	Remove/graft bone lesion	252	19.39	$1,025.49	$509.18	$205.10
24130	T	Removal of head of radius	252	19.39	$1,025.49	$509.18	$205.10
24134	T	Removal of arm bone lesion	252	19.39	$1,025.49	$509.18	$205.10
24136	T	Remove radius bone lesion	252	19.39	$1,025.49	$509.18	$205.10
24138	T	Remove elbow bone lesion	252	19.39	$1,025.49	$509.18	$205.10
24140	T	Partial removal of arm bone	252	19.39	$1,025.49	$509.18	$205.10
24145	T	Partial removal of radius	252	19.39	$1,025.49	$509.18	$205.10
24147	T	Partial removal of elbow	252	19.39	$1,025.49	$509.18	$205.10
24149	C	Radical resection of elbow	.....	.....	.....	.....	.....
24150	C	Extensive humerus surgery	.....	.....	.....	.....	.....
24151	C	Extensive humerus surgery	.....	.....	.....	.....	.....
24152	C	Extensive radius surgery	.....	.....	.....	.....	.....
24153	C	Extensive radius surgery	.....	.....	.....	.....	.....
24155	T	Removal of elbow joint	253	26.33	$1,392.78	$699.24	$278.56
24160	T	Remove elbow joint implant	252	19.39	$1,025.49	$509.18	$205.10
24164	T	Remove radius head implant	252	19.39	$1,025.49	$509.18	$205.10
24200	T	Removal of arm foreign body	161	3.50	$185.12	$75.48	$37.02
24201	T	Removal of arm foreign body	163	10.69	$565.14	$264.65	$113.03
24220	T	Injection for elbow x-ray	347	2.93	$154.75	$62.15	$30.95
24301	T	Muscle/tendon transfer	252	19.39	$1,025.49	$509.18	$205.10
24305	T	Arm tendon lengthening	252	19.39	$1,025.49	$509.18	$205.10
24310	T	Revision of arm tendon	251	14.26	$754.18	$366.12	$150.84
24320	T	Repair of arm tendon	253	26.33	$1,392.78	$699.24	$278.56
24330	T	Revision of arm muscles	253	26.33	$1,392.78	$699.24	$278.56
24331	T	Revision of arm muscles	253	26.33	$1,392.78	$699.24	$278.56
24340	T	Repair of biceps tendon	253	26.33	$1,392.78	$699.24	$278.56
24341	T	Repair tendon/muscle arm	253	26.33	$1,392.78	$699.24	$278.56
24342	T	Repair of ruptured tendon	253	26.33	$1,392.78	$699.24	$278.56
24350	T	Repair of tennis elbow	252	19.39	$1,025.49	$509.18	$205.10
24351	T	Repair of tennis elbow	252	19.39	$1,025.49	$509.18	$205.10
24352	T	Repair of tennis elbow	252	19.39	$1,025.49	$509.18	$205.10
24354	T	Repair of tennis elbow	252	19.39	$1,025.49	$509.18	$205.10
24356	T	Revision of tennis elbow	252	19.39	$1,025.49	$509.18	$205.10
24360	T	Reconstruct elbow joint	217	20.48	$1,083.27	$526.81	$216.65
24361	T	Reconstruct elbow joint	218	27.50	$1,454.49	$715.52	$290.90
24362	T	Reconstruct elbow joint	218	27.50	$1,454.49	$715.52	$290.90
24363	T	Replace elbow joint	218	27.50	$1,454.49	$715.52	$290.90
24365	T	Reconstruct head of radius	217	20.48	$1,083.27	$526.81	$216.65
24366	T	Reconstruct head of radius	218	27.50	$1,454.49	$715.52	$290.90
24400	T	Revision of humerus	252	19.39	$1,025.49	$509.18	$205.10
24410	T	Revision of humerus	252	19.39	$1,025.49	$509.18	$205.10
24420	T	Revision of humerus	253	26.33	$1,392.78	$699.24	$278.56
24430	T	Repair of humerus	253	26.33	$1,392.78	$699.24	$278.56
24435	T	Repair humerus with graft	253	26.33	$1,392.78	$699.24	$278.56
24470	T	Revision of elbow joint	253	26.33	$1,392.78	$699.24	$278.56
24495	T	Decompression of forearm	252	19.39	$1,025.49	$509.18	$205.10
24498	T	Reinforce humerus	253	26.33	$1,392.78	$699.24	$278.56
24500	T	Treat humerus fracture	209	1.94	$102.84	$37.29	$20.57
24505	T	Treat humerus fracture	209	1.94	$102.84	$37.29	$20.57
24515	T	Repair humerus fracture	216	20.13	$1,064.67	$520.93	$212.93
24516	T	Repair humerus fracture	216	20.13	$1,064.67	$520.93	$212.93
24530	T	Treat humerus fracture	209	1.94	$102.84	$37.29	$20.57
24535	T	Treat humerus fracture	209	1.94	$102.84	$37.29	$20.57
24538	T	Treat humerus fracture	216	20.13	$1,064.67	$520.93	$212.93
24545	T	Repair humerus fracture	216	20.13	$1,064.67	$520.93	$212.93
24546	T	Repair humerus fracture	216	20.13	$1,064.67	$520.93	$212.93
24560	T	Treat humerus fracture	209	1.94	$102.84	$37.29	$20.57
24565	T	Treat humerus fracture	209	1.94	$102.84	$37.29	$20.57
24566	T	Treat humerus fracture	216	20.13	$1,064.67	$520.93	$212.93
24575	T	Repair humerus fracture	216	20.13	$1,064.67	$520.93	$212.93
24576	T	Treat humerus fracture	209	1.94	$102.84	$37.29	$20.57
24577	T	Treat humerus fracture	209	1.94	$102.84	$37.29	$20.57
24579	T	Repair humerus fracture	216	20.13	$1,064.67	$520.93	$212.93
24582	T	Treat humerus fracture	216	20.13	$1,064.67	$520.93	$212.93

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
24586	T	Repair elbow fracture	216	20.13	$1,064.67	$520.93	$212.93
24587	T	Repair elbow fracture	216	20.13	$1,064.67	$520.93	$212.93
24600	T	Treat elbow dislocation	209	1.94	$102.84	$37.29	$20.57
24605	T	Treat elbow dislocation	210	10.46	$553.39	$283.40	$110.68
24615	T	Repair elbow dislocation	216	20.13	$1,064.67	$520.93	$212.93
24620	T	Treat elbow fracture	209	1.94	$102.84	$37.29	$20.57
24635	T	Repair elbow fracture	216	20.13	$1,064.67	$520.93	$212.93
24640	T	Treat elbow dislocation	209	1.94	$102.84	$37.29	$20.57
24650	T	Treat radius fracture	209	1.94	$102.84	$37.29	$20.57
24655	T	Treat radius fracture	209	1.94	$102.84	$37.29	$20.57
24665	T	Repair radius fracture	216	20.13	$1,064.67	$520.93	$212.93
24666	T	Repair radius fracture	216	20.13	$1,064.67	$520.93	$212.93
24670	T	Treatment of ulna fracture	209	1.94	$102.84	$37.29	$20.57
24675	T	Treatment of ulna fracture	209	1.94	$102.84	$37.29	$20.57
24685	T	Repair ulna fracture	216	20.13	$1,064.67	$520.93	$212.93
24800	T	Fusion of elbow joint	253	26.33	$1,392.78	$699.24	$278.56
24802	T	Fusion/graft of elbow joint	253	26.33	$1,392.78	$699.24	$278.56
24900	C	Amputation of upper arm	.....	.....	.....	.....	.....
24920	C	Amputation of upper arm	.....	.....	.....	.....	.....
24925	T	Amputation follow-up surgery	251	14.26	$754.18	$366.12	$150.84
24930	C	Amputation follow-up surgery	.....	.....	.....	.....	.....
24931	C	Amputate upper arm & implant	.....	.....	.....	.....	.....
24935	C	Revision of amputation	.....	.....	.....	.....	.....
24940	C	Revision of upper arm	.....	.....	.....	.....	.....
24999	T	Upper arm/elbow surgery	209	1.94	$102.84	$37.29	$20.57
25000	T	Incision of tendon sheath	251	14.26	$754.18	$366.12	$150.84
25020	T	Decompression of forearm	251	14.26	$754.18	$366.12	$150.84
25023	T	Decompression of forearm	252	19.39	$1,025.49	$509.18	$205.10
25028	T	Drainage of forearm lesion	251	14.26	$754.18	$366.12	$150.84
25031	T	Drainage of forearm bursa	251	14.26	$754.18	$366.12	$150.84
25035	T	Treat forearm bone lesion	251	14.26	$754.18	$366.12	$150.84
25040	T	Explore/treat wrist joint	252	19.39	$1,025.49	$509.18	$205.10
25065	T	Biopsy forearm soft tissues	161	3.50	$185.12	$75.48	$37.02
25066	T	Biopsy forearm soft tissues	163	10.69	$565.14	$264.65	$113.03
25075	T	Removal of forearm lesion	162	5.67	$299.71	$125.43	$59.94
25076	T	Removal of forearm lesion	163	10.69	$565.14	$264.65	$113.03
25077	T	Remove tumor, forearm/wrist	163	10.69	$565.14	$264.65	$113.03
25085	T	Incision of wrist capsule	251	14.26	$754.18	$366.12	$150.84
25100	T	Biopsy of wrist joint	251	14.26	$754.18	$366.12	$150.84
25101	T	Explore/treat wrist joint	252	19.39	$1,025.49	$509.18	$205.10
25105	T	Remove wrist joint lining	252	19.39	$1,025.49	$509.18	$205.10
25107	T	Remove wrist joint cartilage	252	19.39	$1,025.49	$509.18	$205.10
25110	T	Remove wrist tendon lesion	251	14.26	$754.18	$366.12	$150.84
25111	T	Remove wrist tendon lesion	261	10.54	$557.31	$261.48	$111.46
25112	T	Remove wrist tendon lesion	261	10.54	$557.31	$261.48	$111.46
25115	T	Remove wrist/forearm lesion	251	14.26	$754.18	$366.12	$150.84
25116	T	Remove wrist/forearm lesion	251	14.26	$754.18	$366.12	$150.84
25118	T	Excise wrist tendon sheath	252	19.39	$1,025.49	$509.18	$205.10
25119	T	Partial removal of ulna	252	19.39	$1,025.49	$509.18	$205.10
25120	T	Removal of forearm lesion	252	19.39	$1,025.49	$509.18	$205.10
25125	T	Remove/graft forearm lesion	252	19.39	$1,025.49	$509.18	$205.10
25126	T	Remove/graft forearm lesion	252	19.39	$1,025.49	$509.18	$205.10
25130	T	Removal of wrist lesion	252	19.39	$1,025.49	$509.18	$205.10
25135	T	Remove & graft wrist lesion	252	19.39	$1,025.49	$509.18	$205.10
25136	T	Remove & graft wrist lesion	252	19.39	$1,025.49	$509.18	$205.10
25145	T	Remove forearm bone lesion	252	19.39	$1,025.49	$509.18	$205.10
25150	T	Partial removal of ulna	252	19.39	$1,025.49	$509.18	$205.10
25151	T	Partial removal of radius	252	19.39	$1,025.49	$509.18	$205.10
25170	C	Extensive forearm surgery	.....	.....	.....	.....	.....
25210	T	Removal of wrist bone	262	18.35	$970.64	$480.93	$194.13
25215	T	Removal of wrist bones	262	18.35	$970.64	$480.93	$194.13
25230	T	Partial removal of radius	252	19.39	$1,025.49	$509.18	$205.10
25240	T	Partial removal of ulna	252	19.39	$1,025.49	$509.18	$205.10
25246	T	Injection for wrist x-ray	347	2.93	$154.75	$62.15	$30.95
25248	T	Remove forearm foreign body	251	14.26	$754.18	$366.12	$150.84
25250	T	Removal of wrist prosthesis	252	19.39	$1,025.49	$509.18	$205.10
25251	T	Removal of wrist prosthesis	252	19.39	$1,025.49	$509.18	$205.10
25260	T	Repair forearm tendon/muscle	252	19.39	$1,025.49	$509.18	$205.10
25263	T	Repair forearm tendon/muscle	252	19.39	$1,025.49	$509.18	$205.10
25265	T	Repair forearm tendon/muscle	252	19.39	$1,025.49	$509.18	$205.10
25270	T	Repair forearm tendon/muscle	252	19.39	$1,025.49	$509.18	$205.10
25272	T	Repair forearm tendon/muscle	252	19.39	$1,025.49	$509.18	$205.10
25274	T	Repair forearm tendon/muscle	252	19.39	$1,025.49	$509.18	$205.10
25280	T	Revise wrist/forearm tendon	252	19.39	$1,025.49	$509.18	$205.10
25290	T	Incise wrist/forearm tendon	252	19.39	$1,025.49	$509.18	$205.10

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
25295	T	Release wrist/forearm tendon	251	14.26	$754.18	$366.12	$150.84
25300	T	Fusion of tendons at wrist	252	19.39	$1,025.49	$509.18	$205.10
25301	T	Fusion of tendons at wrist	252	19.39	$1,025.49	$509.18	$205.10
25310	T	Transplant forearm tendon	253	26.33	$1,392.78	$699.24	$278.56
25312	T	Transplant forearm tendon	253	26.33	$1,392.78	$699.24	$278.56
25315	T	Revise palsy hand tendon(s)	253	26.33	$1,392.78	$699.24	$278.56
25316	T	Revise palsy hand tendon(s)	253	26.33	$1,392.78	$699.24	$278.56
25320	T	Repair/revise wrist joint	253	26.33	$1,392.78	$699.24	$278.56
25332	T	Revise wrist joint	217	20.48	$1,083.27	$526.81	$216.65
25335	T	Realignment of hand	253	26.33	$1,392.78	$699.24	$278.56
25337	T	Reconstruct ulna/radioulnar	253	26.33	$1,392.78	$699.24	$278.56
25350	T	Revision of radius	253	26.33	$1,392.78	$699.24	$278.56
25355	T	Revision of radius	253	26.33	$1,392.78	$699.24	$278.56
25360	T	Revision of ulna	252	19.39	$1,025.49	$509.18	$205.10
25365	T	Revise radius & ulna	252	19.39	$1,025.49	$509.18	$205.10
25370	T	Revise radius or ulna	253	26.33	$1,392.78	$699.24	$278.56
25375	T	Revise radius & ulna	253	26.33	$1,392.78	$699.24	$278.56
25390	C	Shorten radius/ulna					
25391	C	Lengthen radius/ulna					
25392	C	Shorten radius & ulna					
25393	C	Lengthen radius & ulna					
25400	T	Repair radius or ulna	252	19.39	$1,025.49	$509.18	$205.10
25405	C	Repair/graft radius or ulna					
25415	T	Repair radius & ulna	252	19.39	$1,025.49	$509.18	$205.10
25420	C	Repair/graft radius & ulna					
25425	T	Repair/graft radius or ulna	253	26.33	$1,392.78	$699.24	$278.56
25426	T	Repair/graft radius & ulna	253	26.33	$1,392.78	$699.24	$278.56
25440	T	Repair/graft wrist bone	253	26.33	$1,392.78	$699.24	$278.56
25441	T	Reconstruct wrist joint	218	27.50	$1,454.49	$715.52	$290.90
25442	T	Reconstruct wrist joint	218	27.50	$1,454.49	$715.52	$290.90
25443	T	Reconstruct wrist joint	218	27.50	$1,454.49	$715.52	$290.90
25444	T	Reconstruct wrist joint	218	27.50	$1,454.49	$715.52	$290.90
25445	T	Reconstruct wrist joint	218	27.50	$1,454.49	$715.52	$290.90
25446	T	Wrist replacement	218	27.50	$1,454.49	$715.52	$290.90
25447	T	Repair wrist joint(s)	217	20.48	$1,083.27	$526.81	$216.65
25449	T	Remove wrist joint implant	217	20.48	$1,083.27	$526.81	$216.65
25450	T	Revision of wrist joint	253	26.33	$1,392.78	$699.24	$278.56
25455	T	Revision of wrist joint	253	26.33	$1,392.78	$699.24	$278.56
25490	T	Reinforce radius	253	26.33	$1,392.78	$699.24	$278.56
25491	T	Reinforce ulna	253	26.33	$1,392.78	$699.24	$278.56
25492	T	Reinforce radius and ulna	253	26.33	$1,392.78	$699.24	$278.56
25500	T	Treat fracture of radius	209	1.94	$102.84	$37.29	$20.57
25505	T	Treat fracture of radius	209	1.94	$102.84	$37.29	$20.57
25515	T	Repair fracture of radius	216	20.13	$1,064.67	$520.93	$212.93
25520	T	Repair fracture of radius	209	1.94	$102.84	$37.29	$20.57
25525	T	Repair fracture of radius	216	20.13	$1,064.67	$520.93	$212.93
25526	T	Repair fracture of radius	216	20.13	$1,064.67	$520.93	$212.93
25530	T	Treat fracture of ulna	209	1.94	$102.84	$37.29	$20.57
25535	T	Treat fracture of ulna	209	1.94	$102.84	$37.29	$20.57
25545	T	Repair fracture of ulna	216	20.13	$1,064.67	$520.93	$212.93
25560	T	Treat fracture radius & ulna	209	1.94	$102.84	$37.29	$20.57
25565	T	Treat fracture radius & ulna	209	1.94	$102.84	$37.29	$20.57
25574	T	Treat fracture radius & ulna	216	20.13	$1,064.67	$520.93	$212.93
25575	T	Repair fracture radius/ulna	216	20.13	$1,064.67	$520.93	$212.93
25600	T	Treat fracture radius/ulna	209	1.94	$102.84	$37.29	$20.57
25605	T	Treat fracture radius/ulna	209	1.94	$102.84	$37.29	$20.57
25611	T	Repair fracture radius/ulna	216	20.13	$1,064.67	$520.93	$212.93
25620	T	Repair fracture radius/ulna	216	20.13	$1,064.67	$520.93	$212.93
25622	T	Treat wrist bone fracture	209	1.94	$102.84	$37.29	$20.57
25624	T	Treat wrist bone fracture	209	1.94	$102.84	$37.29	$20.57
25628	T	Repair wrist bone fracture	216	20.13	$1,064.67	$520.93	$212.93
25630	T	Treat wrist bone fracture	209	1.94	$102.84	$37.29	$20.57
25635	T	Treat wrist bone fracture	209	1.94	$102.84	$37.29	$20.57
25645	T	Repair wrist bone fracture	216	20.13	$1,064.67	$520.93	$212.93
25650	T	Repair wrist bone fracture	209	1.94	$102.84	$37.29	$20.57
25660	T	Treat wrist dislocation	209	1.94	$102.84	$37.29	$20.57
25670	T	Repair wrist dislocation	216	20.13	$1,064.67	$520.93	$212.93
25675	T	Treat wrist dislocation	209	1.94	$102.84	$37.29	$20.57
25676	T	Repair wrist dislocation	216	20.13	$1,064.67	$520.93	$212.93
25680	T	Treat wrist fracture	209	1.94	$102.84	$37.29	$20.57
25685	T	Repair wrist fracture	216	20.13	$1,064.67	$520.93	$212.93
25690	T	Treat wrist dislocation	209	1.94	102.84	$37.29	$20.57
25695	T	Repair wrist dislocation	216	20.13	$1,064.67	$520.93	$212.93
25800	T	Fusion of wrist joint	253	26.33	$1,392.78	$699.24	$278.56
25805	T	Fusion/graft of wrist joint	253	26.33	$1,392.78	$699.24	$278.56

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
25810	T	Fusion/graft of wrist joint	253	26.33	$1,392.78	$699.24	$278.56
25820	T	Fusion of hand bones	261	10.54	$557.31	$261.48	$111.46
25825	T	Fusion hand bones with graft	262	18.35	$970.64	$480.93	$194.13
25830	T	Fusion radioulnar jnt/ulna	253	26.33	$1,392.78	$699.24	$278.56
25900	C	Amputation of forearm	.....	.....	.....	.....	.....
25905	C	Amputation of forearm	.....	.....	.....	.....	.....
25907	T	Amputation follow-up surgery	251	14.26	$754.18	$366.12	$150.84
25909	C	Amputation follow-up surgery	.....	.....	.....	.....	.....
25915	C	Amputation of forearm	.....	.....	.....	.....	.....
25920	C	Amputate hand at wrist	.....	.....	.....	.....	.....
25922	T	Amputate hand at wrist	251	14.26	$754.18	$366.12	$150.84
25924	C	Amputation follow-up surgery	.....	.....	.....	.....	.....
25927	C	Amputation of hand	.....	.....	.....	.....	.....
25929	T	Amputation follow-up surgery	183	11.17	$590.61	$286.57	$118.12
25931	C	Amputation follow-up surgery	.....	.....	.....	.....	.....
25999	T	Forearm or wrist surgery	209	1.94	$102.84	$37.29	$20.57
26010	T	Drainage of finger abscess	131	1.94	$102.84	$36.61	$20.57
26011	T	Drainage of finger abscess	131	1.94	$102.84	$36.61	$20.57
26020	T	Drain hand tendon sheath	261	10.54	$557.31	$261.48	$111.46
26025	T	Drainage of palm bursa	261	10.54	$557.31	$261.48	$111.46
26030	T	Drainage of palm bursa(s)	261	10.54	$557.31	$261.48	$111.46
26034	T	Treat hand bone lesion	261	10.54	$557.31	$261.48	$111.46
26035	T	Decompress fingers/hand	261	10.54	$557.31	$261.48	$111.46
26037	T	Decompress fingers/hand	261	10.54	$557.31	$261.48	$111.46
26040	T	Release palm contracture	262	18.35	$970.64	$480.93	$194.13
26045	T	Release palm contracture	262	18.35	$970.64	$480.93	$194.13
26055	T	Incise finger tendon sheath	261	10.54	$557.31	$261.48	$111.46
26060	T	Incision of finger tendon	261	10.54	$557.31	$261.48	$111.46
26070	T	Explore/treat hand joint	261	10.54	$557.31	$261.48	$111.46
26075	T	Explore/treat finger joint	261	10.54	$557.31	$261.48	$111.46
26080	T	Explore/treat finger joint	261	10.54	$557.31	$261.48	$111.46
26100	T	Biopsy hand joint lining	261	10.54	$557.31	$261.48	$111.46
26105	T	Biopsy finger joint lining	261	10.54	$557.31	$261.48	$111.46
26110	T	Biopsy finger joint lining	261	10.54	$557.31	$261.48	$111.46
26115	T	Removal of hand lesion	163	10.69	$565.14	$264.65	$113.03
26116	T	Removal of hand lesion	163	10.69	$565.14	$264.65	$113.03
26117	T	Remove tumor, hand/finger	163	10.69	$565.14	$264.65	$113.03
26121	T	Release palm contracture	262	18.35	$970.64	$480.93	$194.13
26123	T	Release palm contracture	262	18.35	$970.64	$480.93	$194.13
26125	T	Release palm contracture	262	18.35	$970.64	$480.93	$194.13
26130	T	Remove wrist joint lining	261	10.54	$557.31	$261.48	$111.46
26135	T	Revise finger joint, each	262	18.35	$970.64	$480.93	$194.13
26140	T	Revise finger joint, each	261	10.54	$557.31	$261.48	$111.46
26145	T	Tendon excision, palm/finger	261	10.54	$557.31	$261.48	$111.46
26160	T	Remove tendon sheath lesion	261	10.54	$557.31	$261.48	$111.46
26170	T	Removal of palm tendon, each	261	10.54	$557.31	$261.48	$111.46
26180	T	Removal of finger tendon	261	10.54	$557.31	$261.48	$111.46
26185	T	Remove finger bone	261	10.54	$557.31	$261.48	$111.46
26200	T	Remove hand bone lesion	261	10.54	$557.31	$261.48	$111.46
26205	T	Remove/graft bone lesion	262	18.35	$970.64	$480.93	$194.13
26210	T	Removal of finger lesion	261	10.54	$557.31	$261.48	$111.46
26215	T	Remove/graft finger lesion	261	10.54	$557.31	$261.48	$111.46
26230	T	Partial removal of hand bone	261	10.54	$557.31	$261.48	$111.46
26235	T	Partial removal, finger bone	261	10.54	$557.31	$261.48	$111.46
26236	T	Partial removal, finger bone	261	10.54	$557.31	$261.48	$111.46
26250	T	Extensive hand surgery	261	10.54	$557.31	$261.48	$111.46
26255	T	Extensive hand surgery	262	18.35	$970.64	$480.93	$194.13
26260	T	Extensive finger surgery	261	10.54	$557.31	$261.48	$111.46
26261	T	Extensive finger surgery	261	10.54	$557.31	$261.48	$111.46
26262	T	Partial removal of finger	261	10.54	$557.31	$261.48	$111.46
26320	T	Removal of implant from hand	163	10.69	$565.14	$264.65	$113.03
26350	T	Repair finger/hand tendon	262	18.35	$970.64	$480.93	$194.13
26352	T	Repair/graft hand tendon	262	18.35	$970.64	$480.93	$194.13
26356	T	Repair finger/hand tendon	262	18.35	$970.64	$480.93	$194.13
26357	T	Repair finger/hand tendon	262	18.35	$970.64	$480.93	$194.13
26358	T	Repair/graft hand tendon	262	18.35	$970.64	$480.93	$194.13
26370	T	Repair finger/hand tendon	262	18.35	$970.64	$480.93	$194.13
26372	T	Repair/graft hand tendon	262	18.35	$970.64	$480.93	$194.13
26373	T	Repair finger/hand tendon	262	18.35	$970.64	$480.93	$194.13
26390	T	Revise hand/finger tendon	262	18.35	$970.64	$480.93	$194.13
26392	T	Repair/graft hand tendon	262	18.35	$970.64	$480.93	$194.13
26410	T	Repair hand tendon	261	10.54	$557.31	$261.48	$111.46
26412	T	Repair/graft hand tendon	262	18.35	$970.64	$480.93	$194.13
26415	T	Excision, hand/finger tendon	262	18.35	$970.64	$480.93	$194.13
26416	T	Graft hand or finger tendon	262	18.35	$970.64	$480.93	$194.13

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
26418	T	Repair finger tendon	261	10.54	$557.31	$261.48	$111.46
26420	T	Repair/graft finger tendon	262	18.35	$970.64	$480.93	$194.13
26426	T	Repair finger/hand tendon	262	18.35	$970.64	$480.93	$194.13
26428	T	Repair/graft finger tendon	262	18.35	$970.64	$480.93	$194.13
26432	T	Repair finger tendon	261	10.54	$557.31	$261.48	$111.46
26433	T	Repair finger tendon	261	10.54	$557.31	$261.48	$111.46
26434	T	Repair/graft finger tendon	262	18.35	$970.64	$480.93	$194.13
26437	T	Realignment of tendons	261	10.54	$557.31	$261.48	$111.46
26440	T	Release palm/finger tendon	261	10.54	$557.31	$261.48	$111.46
26442	T	Release palm & finger tendon	262	18.35	$970.64	$480.93	$194.13
26445	T	Release hand/finger tendon	261	10.54	$557.31	$261.48	$111.46
26449	T	Release forearm/hand tendon	262	18.35	$970.64	$480.93	$194.13
26450	T	Incision of palm tendon	261	10.54	$557.31	$261.48	$111.46
26455	T	Incision of finger tendon	261	10.54	$557.31	$261.48	$111.46
26460	T	Incise hand/finger tendon	261	10.54	$557.31	$261.48	$111.46
26471	T	Fusion of finger tendons	261	10.54	$557.31	$261.48	$111.46
26474	T	Fusion of finger tendons	261	10.54	$557.31	$261.48	$111.46
26476	T	Tendon lengthening	261	10.54	$557.31	$261.48	$111.46
26477	T	Tendon shortening	261	10.54	$557.31	$261.48	$111.46
26478	T	Lengthening of hand tendon	261	10.54	$557.31	$261.48	$111.46
26479	T	Shortening of hand tendon	261	10.54	$557.31	$261.48	$111.46
26480	T	Transplant hand tendon	262	18.35	$970.64	$480.93	$194.13
26483	T	Transplant/graft hand tendon	262	18.35	$970.64	$480.93	$194.13
26485	T	Transplant palm tendon	262	18.35	$970.64	$480.93	$194.13
26489	T	Transplant/graft palm tendon	262	18.35	$970.64	$480.93	$194.13
26490	T	Revise thumb tendon	262	18.35	$970.64	$480.93	$194.13
26492	T	Tendon transfer with graft	262	18.35	$970.64	$480.93	$194.13
26494	T	Hand tendon/muscle transfer	262	18.35	$970.64	$480.93	$194.13
26496	T	Revise thumb tendon	262	18.35	$970.64	$480.93	$194.13
26497	T	Finger tendon transfer	262	18.35	$970.64	$480.93	$194.13
26498	T	Finger tendon transfer	262	18.35	$970.64	$480.93	$194.13
26499	T	Revision of finger	262	18.35	$970.64	$480.93	$194.13
26500	T	Hand tendon reconstruction	261	10.54	$557.31	$261.48	$111.46
26502	T	Hand tendon reconstruction	262	18.35	$970.64	$480.93	$194.13
26504	T	Hand tendon reconstruction	262	18.35	$970.64	$480.93	$194.13
26508	T	Release thumb contracture	261	10.54	$557.31	$261.48	$111.46
26510	T	Thumb tendon transfer	262	18.35	$970.64	$480.93	$194.13
26516	T	Fusion of knuckle joint	262	18.35	$970.64	$480.93	$194.13
26517	T	Fusion of knuckle joints	262	18.35	$970.64	$480.93	$194.13
26518	T	Fusion of knuckle joints	262	18.35	$970.64	$480.93	$194.13
26520	T	Release knuckle contracture	261	10.54	$557.31	$261.48	$111.46
26525	T	Release finger contracture	261	10.54	$557.31	$261.48	$111.46
26530	T	Revise knuckle joint	217	20.48	$1,083.27	$526.81	$216.65
26531	T	Revise knuckle with implant	218	27.50	$1,454.49	$715.52	$290.90
26535	T	Revise finger joint	217	20.48	$1,083.27	$526.81	$216.65
26536	T	Revise/implant finger joint	218	27.50	$1,454.49	$715.52	$290.90
26540	T	Repair hand joint	261	10.54	$557.31	$261.48	$111.46
26541	T	Repair hand joint with graft	262	18.35	$970.64	$480.93	$194.13
26542	T	Repair hand joint with graft	261	10.54	$557.31	$261.48	$111.46
26545	T	Reconstruct finger joint	262	18.35	$970.64	$480.93	$194.13
26546	T	Repair non-union hand	262	18.35	$970.64	$480.93	$194.13
26548	T	Reconstruct finger joint	262	18.35	$970.64	$480.93	$194.13
26550	T	Construct thumb replacement	262	18.35	$970.64	$480.93	$194.13
26551	C	Great toe-hand transfer	.....	.....	.....	.....	.....
26553	C	Single toe-hand transfer	.....	.....	.....	.....	.....
26554	C	Double toe-hand transfer	.....	.....	.....	.....	.....
26555	T	Positional change of finger	262	18.35	$970.64	$480.93	$194.13
26556	C	Toe joint transfer	.....	.....	.....	.....	.....
26560	T	Repair of web finger	261	10.54	$557.31	$261.48	$111.46
26561	T	Repair of web finger	262	18.35	$970.64	$480.93	$194.13
26562	T	Repair of web finger	262	18.35	$970.64	$480.93	$194.13
26565	T	Correct metacarpal flaw	262	18.35	$970.64	$480.93	$194.13
26567	T	Correct finger deformity	262	18.35	$970.64	$480.93	$194.13
26568	T	Lengthen metacarpal/finger	262	18.35	$970.64	$480.93	$194.13
26580	T	Repair hand deformity	262	18.35	$970.64	$480.93	$194.13
26585	T	Repair finger deformity	262	18.35	$970.64	$480.93	$194.13
26587	T	Reconstruct extra finger	261	10.54	$557.31	$261.48	$111.46
26590	T	Repair finger deformity	262	18.35	$970.64	$480.93	$194.13
26591	T	Repair muscles of hand	262	18.35	$970.64	$480.93	$194.13
26593	T	Release muscles of hand	261	10.54	$557.31	$261.48	$111.46
26596	T	Excision constricting tissue	262	18.35	$970.64	$480.93	$194.13
26597	T	Release of scar contracture	262	18.35	$970.64	$480.93	$194.13
26600	T	Treat metacarpal fracture	209	1.94	$102.84	$37.29	$20.57
26605	T	Treat metacarpal fracture	209	1.94	$102.84	$37.29	$20.57
26607	T	Treat metacarpal fracture	209	1.94	$102.84	$37.29	$20.57

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
26608	T	Treat metacarpal fracture	216	20.13	$1,064.67	$520.93	$212.93
26615	T	Repair metacarpal fracture	216	20.13	$1,064.67	$520.93	$212.93
26641	T	Treat thumb dislocation	209	1.94	$102.84	$37.29	$20.57
26645	T	Treat thumb fracture	209	1.94	$102.84	$37.29	$20.57
26650	T	Repair thumb fracture	216	20.13	$1,064.67	$520.93	$212.93
26665	T	Repair thumb fracture	216	20.13	$1,064.67	$520.93	$212.93
26670	T	Treat hand dislocation	209	1.94	$102.84	$37.29	$20.57
26675	T	Treat hand dislocation	210	10.46	$553.39	$283.4	$110.68
26676	T	Pin hand dislocation	216	20.13	$1,064.67	$520.93	$212.93
26685	T	Repair hand dislocation	216	20.13	$1,064.67	$520.93	$212.93
26686	T	Repair hand dislocation	216	20.13	$1,064.67	$520.93	$212.93
26700	T	Treat knuckle dislocation	207	1.70	$90.11	$31.64	$18.02
26705	T	Treat knuckle dislocation	210	10.46	$553.39	$283.4	$110.68
26706	T	Pin knuckle dislocation	209	1.94	$102.84	$37.29	$20.57
26715	T	Repair knuckle dislocation	216	20.13	$1,064.67	$520.93	$212.93
26720	T	Treat finger fracture, each	207	1.70	$90.11	$31.64	$18.02
26725	T	Treat finger fracture, each	207	1.70	$90.11	$31.64	$18.02
26727	T	Treat finger fracture, each	216	20.13	$1,064.67	$520.93	$212.93
26735	T	Repair finger fracture, each	216	20.13	$1,064.67	$520.93	$212.93
26740	T	Treat finger fracture, each	207	1.70	$90.11	$31.64	$18.02
26742	T	Treat finger fracture, each	209	1.94	$102.84	$37.29	$20.57
26746	T	Repair finger fracture, each	216	20.13	$1,064.67	$520.93	$212.93
26750	T	Treat finger fracture, each	207	1.70	$90.11	$31.64	$18.02
26755	T	Treat finger fracture, each	207	1.70	$90.11	$31.64	$18.02
26756	T	Pin finger fracture, each	216	20.13	$1,064.67	$520.93	$212.93
26765	T	Repair finger fracture, each	216	20.13	$1,064.67	$520.93	$212.93
26770	T	Treat finger dislocation	207	1.70	$90.11	$31.64	$18.02
26775	T	Treat finger dislocation	210	10.46	$553.39	$283.4	$110.68
26776	T	Pin finger dislocation	216	20.13	$1,064.67	$520.93	$212.93
26785	T	Repair finger dislocation	216	20.13	$1,064.67	$520.93	$212.93
26820	T	Thumb fusion with graft	262	18.35	$970.64	$480.93	$194.13
26841	T	Fusion of thumb	262	18.35	$970.64	$480.93	$194.13
26842	T	Thumb fusion with graft	262	18.35	$970.64	$480.93	$194.13
26843	T	Fusion of hand joint	262	18.35	$970.64	$480.93	$194.13
26844	T	Fusion/graft of hand joint	262	18.35	$970.64	$480.93	$194.13
26850	T	Fusion of knuckle	262	18.35	$970.64	$480.93	$194.13
26852	T	Fusion of knuckle with graft	262	18.35	$970.64	$480.93	$194.13
26860	T	Fusion of finger joint	262	18.35	$970.64	$480.93	$194.13
26861	T	Fusion of finger joint, added	262	18.35	$970.64	$480.93	$194.13
26862	T	Fusion/graft of finger joint	262	18.35	$970.64	$480.93	$194.13
26863	T	Fuse/graft added joint	262	18.35	$970.64	$480.93	$194.13
26910	T	Amputate metacarpal bone	262	18.35	$970.64	$480.93	$194.13
26951	T	Amputation of finger/thumb	261	10.54	$557.31	$261.48	$111.46
26952	T	Amputation of finger/thumb	261	10.54	$557.31	$261.48	$111.46
26989	T	Hand/finger surgery	207	1.70	$90.11	$31.64	$18.02
26990	T	Drainage of pelvis lesion	251	14.26	$754.18	$366.12	$150.84
26991	T	Drainage of pelvis bursa	251	14.26	$754.18	$366.12	$150.84
26992	C	Drainage of bone lesion	.....	.....	.....	.....	.....
27000	T	Incision of hip tendon	251	14.26	$754.18	$366.12	$150.84
27001	T	Incision of hip tendon	252	19.39	$1,025.49	$509.18	$205.10
27003	T	Incision of hip tendon	252	19.39	$1,025.49	$509.18	$205.10
27005	C	Incision of hip tendon	.....	.....	.....	.....	.....
27006	C	Incision of hip tendons	.....	.....	.....	.....	.....
27025	C	Incision of hip/thigh fascia	.....	.....	.....	.....	.....
27030	C	Drainage of hip joint	.....	.....	.....	.....	.....
27033	T	Exploration of hip joint	253	26.33	$1,392.78	$699.24	$278.56
27035	C	Denervation of hip joint	.....	.....	.....	.....	.....
27036	C	Excision of hip joint/muscle	.....	.....	.....	.....	.....
27040	T	Biopsy of soft tissues	162	5.67	$299.71	$125.43	$59.94
27041	T	Biopsy of soft tissues	163	10.69	$565.14	$264.65	$113.03
27047	T	Remove hip/pelvis lesion	163	10.69	$565.14	$264.65	$113.03
27048	T	Remove hip/pelvis lesion	163	10.69	$565.14	$264.65	$113.03
27049	T	Remove tumor, hip/pelvis	163	10.69	$565.14	$264.65	$113.03
27050	T	Biopsy of sacroiliac joint	251	14.26	$754.18	$366.12	$150.84
27052	T	Biopsy of hip joint	251	14.26	$754.18	$366.12	$150.84
27054	C	Removal of hip joint lining	.....	.....	.....	.....	.....
27060	T	Removal of ischial bursa	251	14.26	$754.18	$366.12	$150.84
27062	T	Remove femur lesion/bursa	251	14.26	$754.18	$366.12	$150.84
27065	T	Removal of hip bone lesion	251	14.26	$754.18	$366.12	$150.84
27066	T	Removal of hip bone lesion	252	19.39	$1,025.49	$509.18	$205.10
27067	T	Remove/graft hip bone lesion	252	19.39	$1,025.49	$509.18	$205.10
27070	C	Partial removal of hip bone	.....	.....	.....	.....	.....
27071	C	Partial removal of hip bone	.....	.....	.....	.....	.....
27075	C	Extensive hip surgery	.....	.....	.....	.....	.....
27076	C	Extensive hip surgery	.....	.....	.....	.....	.....

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
27077	C	Extensive hip surgery	.....	.....	.....	.....	.....
27078	C	Extensive hip surgery	.....	.....	.....	.....	.....
27079	C	Extensive hip surgery	.....	.....	.....	.....	.....
27080	T	Removal of tail bone	252	19.39	$1,025.49	$509.18	$205.10
27086	T	Remove hip foreign body	251	14.26	$754.18	$366.12	$150.84
27087	T	Remove hip foreign body	251	14.26	$754.18	$366.12	$150.84
27090	C	Removal of hip prosthesis	.....	.....	.....	.....	.....
27091	C	Removal of hip prosthesis	.....	.....	.....	.....	.....
27093	T	Injection for hip x-ray	347	2.93	$154.75	$62.15	$30.95
27095	T	Injection for hip x-ray	347	2.93	$154.75	$62.15	$30.95
27097	T	Revision of hip tendon	252	19.39	$1,025.49	$509.18	$205.10
27098	T	Transfer tendon to pelvis	252	19.39	$1,025.49	$509.18	$205.10
27100	T	Transfer of abdominal muscle	253	26.33	$1,392.78	$699.24	$278.56
27105	T	Transfer of spinal muscle	253	26.33	$1,392.78	$699.24	$278.56
27110	T	Transfer of iliopsoas muscle	253	26.33	$1,392.78	$699.24	$278.56
27111	T	Transfer of iliopsoas muscle	253	26.33	$1,392.78	$699.24	$278.56
27120	C	Reconstruction of hip socket	.....	.....	.....	.....	.....
27122	C	Reconstruction of hip socket	.....	.....	.....	.....	.....
27125	C	Partial hip replacement	.....	.....	.....	.....	.....
27130	C	Total hip replacement	.....	.....	.....	.....	.....
27132	C	Total hip replacement	.....	.....	.....	.....	.....
27134	C	Revise hip joint replacement	.....	.....	.....	.....	.....
27137	C	Revise hip joint replacement	.....	.....	.....	.....	.....
27138	C	Revise hip joint replacement	.....	.....	.....	.....	.....
27140	C	Transplant of femur ridge	.....	.....	.....	.....	.....
27146	C	Incision of hip bone	.....	.....	.....	.....	.....
27147	C	Revision of hip bone	.....	.....	.....	.....	.....
27151	C	Incision of hip bones	.....	.....	.....	.....	.....
27156	C	Revision of hip bones	.....	.....	.....	.....	.....
27158	C	Revision of pelvis	.....	.....	.....	.....	.....
27161	C	Incision of neck of femur	.....	.....	.....	.....	.....
27165	C	Incision/fixation of femur	.....	.....	.....	.....	.....
27170	C	Repair/graft femur head/neck	.....	.....	.....	.....	.....
27175	C	Treat slipped epiphysis	.....	.....	.....	.....	.....
27176	C	Treat slipped epiphysis	.....	.....	.....	.....	.....
27177	C	Repair slipped epiphysis	.....	.....	.....	.....	.....
27178	C	Repair slipped epiphysis	.....	.....	.....	.....	.....
27179	C	Revise head/neck of femur	.....	.....	.....	.....	.....
27181	C	Repair slipped epiphysis	.....	.....	.....	.....	.....
27185	C	Revision of femur epiphysis	.....	.....	.....	.....	.....
27187	C	Reinforce hip bones	.....	.....	.....	.....	.....
27193	T	Treat pelvic ring fracture	209	1.94	$102.84	$37.29	$20.57
27194	T	Treat pelvic ring fracture	210	10.46	$553.39	$283.4	$110.68
27200	T	Treat tail bone fracture	207	1.70	$90.11	$31.64	$18.02
27202	T	Repair tail bone fracture	216	20.13	$1,064.67	$520.93	$212.93
27215	C	Pelvic fracture(s) treatment	.....	.....	.....	.....	.....
27216	C	Treat pelvic ring fracture	.....	.....	.....	.....	.....
27217	C	Treat pelvic ring fracture	.....	.....	.....	.....	.....
27218	C	Treat pelvic ring fracture	.....	.....	.....	.....	.....
27220	T	Treat hip socket fracture	209	1.94	$102.84	$37.29	$20.57
27222	C	Treat hip socket fracture	.....	.....	.....	.....	.....
27226	C	Treat hip wall fracture	.....	.....	.....	.....	.....
27227	C	Treat hip fracture(s)	.....	.....	.....	.....	.....
27228	C	Treat hip fracture(s)	.....	.....	.....	.....	.....
27230	T	Treat fracture of thigh	209	1.94	$102.84	$37.29	$20.57
27232	C	Treat fracture of thigh	.....	.....	.....	.....	.....
27235	C	Repair of thigh fracture	.....	.....	.....	.....	.....
27236	C	Repair of thigh fracture	.....	.....	.....	.....	.....
27238	T	Treatment of thigh fracture	209	1.94	$102.84	$37.29	$20.57
27240	C	Treatment of thigh fracture	.....	.....	.....	.....	.....
27244	C	Repair of thigh fracture	.....	.....	.....	.....	.....
27245	C	Repair of thigh fracture	.....	.....	.....	.....	.....
27246	T	Treatment of thigh fracture	209	1.94	$102.84	$37.29	$20.57
27248	C	Repair of thigh fracture	.....	.....	.....	.....	.....
27250	T	Treat hip dislocation	209	1.94	$102.84	$37.29	$20.57
27252	T	Treat hip dislocation	210	10.46	$553.39	$283.4	$110.68
27253	C	Repair of hip dislocation	.....	.....	.....	.....	.....
27254	C	Repair of hip dislocation	.....	.....	.....	.....	.....
27256	T	Treatment of hip dislocation	209	1.94	$102.84	$37.29	$20.57
27257	T	Treatment of hip dislocation	210	10.46	$553.39	$283.4	$110.68
27258	C	Repair of hip dislocation	.....	.....	.....	.....	.....
27259	C	Repair of hip dislocation	.....	.....	.....	.....	.....
27265	T	Treatment of hip dislocation	209	1.94	$102.84	$37.29	$20.57
27266	T	Treatment of hip dislocation	217	20.48	$1,083.27	$526.81	$216.65
27275	T	Manipulation of hip joint	210	10.46	$553.39	$283.4	$110.68

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
27280	C	Fusion of sacroiliac joint	.....	.....	.....	.....	.....
27282	C	Fusion of pubic bones	.....	.....	.....	.....	.....
27284	C	Fusion of hip joint	.....	.....	.....	.....	.....
27286	C	Fusion of hip joint	.....	.....	.....	.....	.....
27290	C	Amputation of leg at hip	.....	.....	.....	.....	.....
27295	C	Amputation of leg at hip	.....	.....	.....	.....	.....
27299	T	Pelvis/hip joint surgery	207	1.70	$90.11	$31.64	$18.02
27301	T	Drain thigh/knee lesion	132	6.04	$319.3	$134.24	$63.86
27303	C	Drainage of bone lesion	.....	.....	.....	.....	.....
27305	T	Incise thigh tendon & fascia	251	14.26	$754.18	$366.12	$150.84
27306	T	Incision of thigh tendon	251	14.26	$754.18	$366.12	$150.84
27307	T	Incision of thigh tendons	251	14.26	$754.18	$366.12	$150.84
27310	T	Exploration of knee joint	252	19.39	$1,025.49	$509.18	$205.10
27315	T	Partial removal, thigh nerve	631	12.98	$686.6	$333.8	$137.32
27320	T	Partial removal, thigh nerve	631	12.98	$686.6	$333.8	$137.32
27323	T	Biopsy thigh soft tissues	162	5.67	$299.71	$125.43	$59.94
27324	T	Biopsy thigh soft tissues	163	10.69	$565.14	$264.65	$113.03
27327	T	Removal of thigh lesion	163	10.69	$565.14	$264.65	$113.03
27328	T	Removal of thigh lesion	163	10.69	$565.14	$264.65	$113.03
27329	T	Remove tumor, thigh/knee	163	10.69	$565.14	$264.65	$113.03
27330	T	Biopsy knee joint lining	252	19.39	$1,025.49	$509.18	$205.10
27331	T	Explore/treat knee joint	252	19.39	$1,025.49	$509.18	$205.10
27332	T	Removal of knee cartilage	252	19.39	$1,025.49	$509.18	$205.10
27333	T	Removal of knee cartilage	252	19.39	$1,025.49	$509.18	$205.10
27334	T	Remove knee joint lining	252	19.39	$1,025.49	$509.18	$205.10
27335	T	Remove knee joint lining	252	19.39	$1,025.49	$509.18	$205.10
27340	T	Removal of kneecap bursa	251	14.26	$754.18	$366.12	$150.84
27345	T	Removal of knee cyst	251	14.26	$754.18	$366.12	$150.84
27350	T	Removal of kneecap	252	19.39	$1,025.49	$509.18	$205.10
27355	T	Remove femur lesion	252	19.39	$1,025.49	$509.18	$205.10
27356	T	Remove femur lesion/graft	252	19.39	$1,025.49	$509.18	$205.10
27357	T	Remove femur lesion/graft	252	19.39	$1,025.49	$509.18	$205.10
27358	T	Remove femur lesion/fixation	252	19.39	$1,025.49	$509.18	$205.10
27360	T	Partial removal leg bone(s)	252	19.39	$1,025.49	$509.18	$205.10
27365	C	Extensive leg surgery	.....	.....	.....	.....	.....
27370	T	Injection for knee x-ray	347	2.93	$154.75	$62.15	$30.95
27372	T	Removal of foreign body	163	10.69	$565.14	$264.65	$113.03
27380	T	Repair of kneecap tendon	251	14.26	$754.18	$366.12	$150.84
27381	T	Repair/graft kneecap tendon	251	14.26	$754.18	$366.12	$150.84
27385	T	Repair of thigh muscle	251	14.26	$754.18	$366.12	$150.84
27386	T	Repair/graft of thigh muscle	251	14.26	$754.18	$366.12	$150.84
27390	T	Incision of thigh tendon	251	14.26	$754.18	$366.12	$150.84
27391	T	Incision of thigh tendons	251	14.26	$754.18	$366.12	$150.84
27392	T	Incision of thigh tendons	251	14.26	$754.18	$366.12	$150.84
27393	T	Lengthening of thigh tendon	252	19.39	$1,025.49	$509.18	$205.10
27394	T	Lengthening of thigh tendons	252	19.39	$1,025.49	$509.18	$205.10
27395	T	Lengthening of thigh tendons	253	26.33	$1,392.78	$699.24	$278.56
27396	T	Transplant of thigh tendon	252	19.39	$1,025.49	$509.18	$205.10
27397	T	Transplants of thigh tendons	253	26.33	$1,392.78	$699.24	$278.56
27400	T	Revise thigh muscles/tendons	253	26.33	$1,392.78	$699.24	$278.56
27403	T	Repair of knee cartilage	252	19.39	$1,025.49	$509.18	$205.10
27405	T	Repair of knee ligament	253	26.33	$1,392.78	$699.24	$278.56
27407	T	Repair of knee ligament	253	26.33	$1,392.78	$699.24	$278.56
27409	T	Repair of knee ligaments	253	26.33	$1,392.78	$699.24	$278.56
27418	T	Repair degenerated kneecap	253	26.33	$1,392.78	$699.24	$278.56
27420	T	Revision of unstable kneecap	253	26.33	$1,392.78	$699.24	$278.56
27422	T	Revision of unstable kneecap	253	26.33	$1,392.78	$699.24	$278.56
27424	T	Revision/removal of kneecap	253	26.33	$1,392.78	$699.24	$278.56
27425	T	Lateral retinacular release	252	19.39	$1,025.49	$509.18	$205.10
27427	T	Reconstruction, knee	254	34.37	$1,817.86	$937.22	$363.57
27428	T	Reconstruction, knee	254	34.37	$1,817.86	$937.22	$363.57
27429	T	Reconstruction, knee	254	34.37	$1,817.86	$937.22	$363.57
27430	T	Revision of thigh muscles	253	26.33	$1,392.78	$699.24	$278.56
27435	T	Incision of knee joint	253	26.33	$1,392.78	$699.24	$278.56
27437	T	Revise kneecap	217	20.48	$1,083.27	$526.81	$216.65
27438	T	Revise kneecap with implant	218	27.50	$1,454.49	$715.52	$290.90
27440	T	Revision of knee joint	217	20.48	$1,083.27	$526.81	$216.65
27441	T	Revision of knee joint	217	20.48	$1,083.27	$526.81	$216.65
27442	T	Revision of knee joint	217	20.48	$1,083.27	$526.81	$216.65
27443	T	Revision of knee joint	217	20.48	$1,083.27	$526.81	$216.65
27445	C	Revision of knee joint	.....	.....	.....	.....	.....
27446	C	Revision of knee joint	.....	.....	.....	.....	.....
27447	C	Total knee replacement	.....	.....	.....	.....	.....
27448	C	Incision of thigh	.....	.....	.....	.....	.....
27450	C	Incision of thigh	.....	.....	.....	.....	.....

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
27454	C	Realignment of thigh bone					
27455	C	Realignment of knee					
27457	C	Realignment of knee					
27465	C	Shortening of thigh bone					
27466	C	Lengthening of thigh bone					
27468	C	Shorten/lengthen thighs					
27470	C	Repair of thigh					
27472	C	Repair/graft of thigh					
27475	C	Surgery to stop leg growth					
27477	C	Surgery to stop leg growth					
27479	C	Surgery to stop leg growth					
27485	C	Surgery to stop leg growth					
27486	C	Revise knee joint replace					
27487	C	Revise knee joint replace					
27488	C	Removal of knee prosthesis					
27495	C	Reinforce thigh					
27496	T	Decompression of thigh/knee	251	14.26	$754.18	$366.12	$150.84
27497	T	Decompression of thigh/knee	251	14.26	$754.18	$366.12	$150.84
27498	T	Decompression of thigh/knee	251	14.26	$754.18	$366.12	$150.84
27499	T	Decompression of thigh/knee	251	14.26	$754.18	$366.12	$150.84
27500	T	Treatment of thigh fracture	209	1.94	$102.84	$37.29	$20.57
27501	T	Treatment of thigh fracture	209	1.94	$102.84	$37.29	$20.57
27502	T	Treatment of thigh fracture	209	1.94	$102.84	$37.29	$20.57
27503	T	Treatment of thigh fracture	209	1.94	$102.84	$37.29	$20.57
27506	C	Repair of thigh fracture					
27507	C	Treatment of thigh fracture					
27508	T	Treatment of thigh fracture	209	1.94	$102.84	$37.29	$20.57
27509	T	Treatment of thigh fracture	216	20.13	$1,064.67	$520.93	$212.93
27510	T	Treatment of thigh fracture	209	1.94	$102.84	$37.29	$20.57
27511	C	Treatment of thigh fracture					
27513	C	Treatment of thigh fracture					
27514	C	Repair of thigh fracture					
27516	T	Repair of thigh growth plate	209	1.94	$102.84	$37.29	$20.57
27517	T	Repair of thigh growth plate	209	1.94	$102.84	$37.29	$20.57
27519	C	Repair of thigh growth plate					
27520	T	Treat kneecap fracture	209	1.94	$102.84	$37.29	$20.57
27524	C	Repair of kneecap fracture					
27530	T	Treatment of knee fracture	209	1.94	$102.84	$37.29	$20.57
27532	T	Treatment of knee fracture	209	1.94	$102.84	$37.29	$20.57
27535	C	Treatment of knee fracture					
27536	C	Repair of knee fracture					
27538	T	Treat knee fracture(s)	209	1.94	$102.84	$37.29	$20.57
27540	C	Repair of knee fracture					
27550	T	Treat knee dislocation	209	1.94	$102.84	$37.29	$20.57
27552	T	Treat knee dislocation	210	10.46	$553.39	$283.40	$110.68
27556	T	Repair of knee dislocation	216	20.13	$1,064.67	$520.93	$212.93
27557	C	Repair of knee dislocation					
27558	C	Repair of knee dislocation					
27560	T	Treat kneecap dislocation	209	1.94	$102.84	$37.29	$20.57
27562	T	Treat kneecap dislocation	210	10.46	$553.39	$283.40	$110.68
27566	T	Repair kneecap dislocation	216	20.13	$1,064.67	$520.93	$212.93
27570	T	Fixation of knee joint	210	10.46	$553.39	$283.40	$110.68
27580	C	Fusion of knee					
27590	C	Amputate leg at thigh					
27591	C	Amputate leg at thigh					
27592	C	Amputate leg at thigh					
27594	T	Amputation follow-up surgery	251	14.26	$754.18	$366.12	$150.84
27596	C	Amputation follow-up surgery					
27598	C	Amputate lower leg at knee					
27599	T	Leg surgery procedure	209	1.94	$102.84	$37.29	$20.57
27600	T	Decompression of lower leg	251	14.26	$754.18	$366.12	$150.84
27601	T	Decompression of lower leg	251	14.26	$754.18	$366.12	$150.84
27602	T	Decompression of lower leg	251	14.26	$754.18	$366.12	$150.84
27603	T	Drain lower leg lesion	132	6.04	$319.3	$134.24	$63.86
27604	T	Drain lower leg bursa	251	14.26	$754.18	$366.12	$150.84
27605	T	Incision of achilles tendon	271	14.41	$762.01	$368.38	$152.40
27606	T	Incision of achilles tendon	251	14.26	$754.18	$366.12	$150.84
27607	T	Treat lower leg bone lesion	251	14.26	$754.18	$366.12	$150.84
27610	T	Explore/treat ankle joint	252	19.39	$1,025.49	$509.18	$205.10
27612	T	Exploration of ankle joint	252	19.39	$1,025.49	$509.18	$205.10
27613	T	Biopsy lower leg soft tissue	161	3.50	$185.12	$75.48	$37.02
27614	T	Biopsy lower leg soft tissue	163	10.69	$565.14	$264.65	$113.03
27615	T	Remove tumor, lower leg	216	20.13	$1,064.67	$520.93	$212.93
27618	T	Remove lower leg lesion	163	10.69	$565.14	$264.65	$113.03
27619	T	Remove lower leg lesion	163	10.69	$565.14	$264.65	$113.03

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
27620	T	Explore, treat ankle joint	252	19.39	$1,025.49	$509.18	$205.10
27625	T	Remove ankle joint lining	252	19.39	$1,025.49	$509.18	$205.10
27626	T	Remove ankle joint lining	252	19.39	$1,025.49	$509.18	$205.10
27630	T	Removal of tendon lesion	251	14.26	$754.18	$366.12	$150.84
27635	T	Remove lower leg bone lesion	252	19.39	$1,025.49	$509.18	$205.10
27637	T	Remove/graft leg bone lesion	252	19.39	$1,025.49	$509.18	$205.10
27638	T	Remove/graft leg bone lesion	252	19.39	$1,025.49	$509.18	$205.10
27640	T	Partial removal of tibia	253	26.33	$1,392.78	$699.24	$278.56
27641	T	Partial removal of fibula	252	19.39	$1,025.49	$509.18	$205.10
27645	C	Extensive lower leg surgery					
27646	C	Extensive lower leg surgery					
27647	T	Extensive ankle/heel surgery	253	26.33	$1,392.78	$699.24	$278.56
27648	T	Injection for ankle x-ray	347	2.93	$154.75	$62.15	$30.95
27650	T	Repair achilles tendon	253	26.33	$1,392.78	$699.24	$278.56
27652	T	Repair/graft achilles tendon	253	26.33	$1,392.78	$699.24	$278.56
27654	T	Repair of achilles tendon	253	26.33	$1,392.78	$699.24	$278.56
27656	T	Repair leg fascia defect	251	14.26	$754.18	$366.12	$150.84
27658	T	Repair of leg tendon, each	251	14.26	$754.18	$366.12	$150.84
27659	T	Repair of leg tendon, each	251	14.26	$754.18	$366.12	$150.84
27664	T	Repair of leg tendon, each	251	14.26	$754.18	$366.12	$150.84
27665	T	Repair of leg tendon, each	252	19.39	$1,025.49	$509.18	$205.10
27675	T	Repair lower leg tendons	251	14.26	$754.18	$366.12	$150.84
27676	T	Repair lower leg tendons	252	19.39	$1,025.49	$509.18	$205.10
27680	T	Release of lower leg tendon	252	19.39	$1,025.49	$509.18	$205.10
27681	T	Release of lower leg tendons	252	19.39	$1,025.49	$509.18	$205.10
27685	T	Revision of lower leg tendon	252	19.39	$1,025.49	$509.18	$205.10
27686	T	Revise lower leg tendons	252	19.39	$1,025.49	$509.18	$205.10
27687	T	Revision of calf tendon	252	19.39	$1,025.49	$509.18	$205.10
27690	T	Revise lower leg tendon	253	26.33	$1,392.78	$699.24	$278.56
27691	T	Revise lower leg tendon	253	26.33	$1,392.78	$699.24	$278.56
27692	T	Revise additional leg tendon	253	26.33	$1,392.78	$699.24	$278.56
27695	T	Repair of ankle ligament	252	19.39	$1,025.49	$509.18	$205.10
27696	T	Repair of ankle ligaments	252	19.39	$1,025.49	$509.18	$205.10
27698	T	Repair of ankle ligament	252	19.39	$1,025.49	$509.18	$205.10
27700	T	Revision of ankle joint	217	20.48	$1,083.27	$526.81	$216.65
27702	C	Reconstruct ankle joint					
27703	C	Reconstruction, ankle joint					
27704	T	Removal of ankle implant	251	14.26	$754.18	$366.12	$150.84
27705	T	Incision of tibia	253	26.33	$1,392.78	$699.24	$278.56
27707	T	Incision of fibula	251	14.26	$754.18	$366.12	$150.84
27709	T	Incision of tibia & fibula	252	19.39	$1,025.49	$509.18	$205.10
27712	C	Realignment of lower leg					
27715	C	Revision of lower leg					
27720	C	Repair of tibia					
27722	C	Repair/graft of tibia					
27724	C	Repair/graft of tibia					
27725	C	Repair of lower leg					
27727	C	Repair of lower leg					
27730	T	Repair of tibia epiphysis	252	19.39	$1,025.49	$509.18	$205.10
27732	T	Repair of fibula epiphysis	252	19.39	$1,025.49	$509.18	$205.10
27734	T	Repair lower leg epiphyses	252	19.39	$1,025.49	$509.18	$205.10
27740	T	Repair of leg epiphyses	252	19.39	$1,025.49	$509.18	$205.10
27742	T	Repair of leg epiphyses	253	26.33	$1,392.78	$699.24	$278.56
27745	T	Reinforce tibia	253	26.33	$1,392.78	$699.24	$278.56
27750	T	Treatment of tibia fracture	209	1.94	$102.84	$37.29	$20.57
27752	T	Treatment of tibia fracture	209	1.94	$102.84	$37.29	$20.57
27756	T	Repair of tibia fracture	216	20.13	$1,064.67	$520.93	$212.93
27758	T	Repair of tibia fracture	216	20.13	$1,064.67	$520.93	$212.93
27759	T	Repair of tibia fracture	216	20.13	$1,064.67	$520.93	$212.93
27760	T	Treatment of ankle fracture	209	1.94	$102.84	$37.29	$20.57
27762	T	Treatment of ankle fracture	209	1.94	$102.84	$37.29	$20.57
27766	T	Repair of ankle fracture	216	20.13	$1,064.67	$520.93	$212.93
27780	T	Treatment of fibula fracture	209	1.94	$102.84	$37.29	$20.57
27781	T	Treatment of fibula fracture	209	1.94	$102.84	$37.29	$20.57
27784	T	Repair of fibula fracture	216	20.13	$1,064.67	$520.93	$212.93
27786	T	Treatment of ankle fracture	209	1.94	$102.84	$37.29	$20.57
27788	T	Treatment of ankle fracture	209	1.94	$102.84	$37.29	$20.57
27792	T	Repair of ankle fracture	216	20.13	$1,064.67	$520.93	$212.93
27808	T	Treatment of ankle fracture	209	1.94	$102.84	$37.29	$20.57
27810	T	Treatment of ankle fracture	209	1.94	$102.84	$37.29	$20.57
27814	T	Repair of ankle fracture	216	20.13	$1,064.67	$520.93	$212.93
27816	T	Treatment of ankle fracture	209	1.94	$102.84	$37.29	$20.57
27818	T	Treatment of ankle fracture	209	1.94	$102.84	$37.29	$20.57
27822	T	Repair of ankle fracture	216	20.13	$1,064.67	$520.93	$212.93
27823	T	Repair of ankle fracture	216	20.13	$1,064.67	$520.93	$212.93

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
27824	T	Treat lower leg fracture	209	1.94	$102.84	$37.29	$20.57
27825	T	Treat lower leg fracture	209	1.94	$102.84	$37.29	$20.57
27826	T	Treat lower leg fracture	216	20.13	$1,064.67	$520.93	$212.93
27827	T	Treat lower leg fracture	216	20.13	$1,064.67	$520.93	$212.93
27828	T	Treat lower leg fracture	216	20.13	$1,064.67	$520.93	$212.93
27829	T	Treat lower leg joint	216	20.13	$1,064.67	$520.93	$212.93
27830	T	Treat lower leg dislocation	209	1.94	$102.84	$37.29	$20.57
27831	T	Treat lower leg dislocation	210	10.46	$553.39	$283.40	$110.68
27832	T	Repair lower leg dislocation	216	20.13	$1,064.67	$520.93	$212.93
27840	T	Treat ankle dislocation	209	1.94	$102.84	$37.29	$20.57
27842	T	Treat ankle dislocation	210	10.46	$553.39	$283.40	$110.68
27846	T	Repair ankle dislocation	216	20.13	$1,064.67	$520.93	$212.93
27848	T	Repair ankle dislocation	216	20.13	$1,064.67	$520.93	$212.93
27860	T	Fixation of ankle joint	210	10.46	$553.39	$283.40	$110.68
27870	T	Fusion of ankle joint	253	26.33	$1,392.78	$699.24	$278.56
27871	T	Fusion of tibiofibular joint	253	26.33	$1,392.78	$699.24	$278.56
27880	C	Amputation of lower leg	.....	.....	.....	.....	.....
27881	C	Amputation of lower leg	.....	.....	.....	.....	.....
27882	C	Amputation of lower leg	.....	.....	.....	.....	.....
27884	T	Amputation follow-up surgery	251	14.26	$754.18	$366.12	$150.84
27886	C	Amputation follow-up surgery	.....	.....	.....	.....	.....
27888	C	Amputation of foot at ankle	.....	.....	.....	.....	.....
27889	T	Amputation of foot at ankle	252	19.39	$1,025.49	$509.18	$205.10
27892	T	Decompression of leg	251	14.26	$754.18	$366.12	$150.84
27893	T	Decompression of leg	251	14.26	$754.18	$366.12	$150.84
27894	T	Decompression of leg	251	14.26	$754.18	$366.12	$150.84
27899	T	Leg/ankle surgery procedure	209	1.94	$102.84	$37.29	$20.57
28001	T	Drainage of bursa of foot	132	6.04	$319.3	$134.24	$63.86
28002	T	Treatment of foot infection	251	14.26	$754.18	$366.12	$150.84
28003	T	Treatment of foot infection	251	14.26	$754.18	$366.12	$150.84
28005	T	Treat foot bone lesion	271	14.41	$762.01	$368.38	$152.40
28008	T	Incision of foot fascia	271	14.41	$762.01	$368.38	$152.40
28010	T	Incision of toe tendon	271	14.41	$762.01	$368.38	$152.40
28011	T	Incision of toe tendons	271	14.41	$762.01	$368.38	$152.40
28020	T	Exploration of a foot joint	271	14.41	$762.01	$368.38	$152.40
28022	T	Exploration of a foot joint	271	14.41	$762.01	$368.38	$152.40
28024	T	Exploration of a toe joint	271	14.41	$762.01	$368.38	$152.40
28030	T	Removal of foot nerve	631	12.98	$686.60	$333.80	$137.32
28035	T	Decompression of tibia nerve	631	12.98	$686.60	$333.80	$137.32
28043	T	Excision of foot lesion	162	5.67	$299.71	$125.43	$59.94
28045	T	Excision of foot lesion	271	14.41	$762.01	$368.38	$152.40
28046	T	Resection of tumor, foot	271	14.41	$762.01	$368.38	$152.40
28050	T	Biopsy of foot joint lining	271	14.41	$762.01	$368.38	$152.40
28052	T	Biopsy of foot joint lining	271	14.41	$762.01	$368.38	$152.40
28054	T	Biopsy of toe joint lining	271	14.41	$762.01	$368.38	$152.40
28060	T	Partial removal foot fascia	272	16.56	$875.63	$409.74	$175.13
28062	T	Removal of foot fascia	272	16.56	$875.63	$409.74	$175.13
28070	T	Removal of foot joint lining	272	16.56	$875.63	$409.74	$175.13
28072	T	Removal of foot joint lining	272	16.56	$875.63	$409.74	$175.13
28080	T	Removal of foot lesion	271	14.41	$762.01	$368.38	$152.40
28086	T	Excise foot tendon sheath	271	14.41	$762.01	$368.38	$152.40
28088	T	Excise foot tendon sheath	271	14.41	$762.01	$368.38	$152.40
28090	T	Removal of foot lesion	271	14.41	$762.01	$368.38	$152.40
28092	T	Removal of toe lesions	271	14.41	$762.01	$368.38	$152.40
28100	T	Removal of ankle/heel lesion	271	14.41	$762.01	$368.38	$152.40
28102	T	Remove/graft foot lesion	272	16.56	$875.63	$409.74	$175.13
28103	T	Remove/graft foot lesion	272	16.56	$875.63	$409.74	$175.13
28104	T	Removal of foot lesion	271	14.41	$762.01	$368.38	$152.40
28106	T	Remove/graft foot lesion	272	16.56	$875.63	$409.74	$175.13
28107	T	Remove/graft foot lesion	272	16.56	$875.63	$409.74	$175.13
28108	T	Removal of toe lesions	271	14.41	$762.01	$368.38	$152.40
28110	T	Part removal of metatarsal	276	19.19	$1,014.71	$500.14	$202.94
28111	T	Part removal of metatarsal	271	14.41	$762.01	$368.38	$152.40
28112	T	Part removal of metatarsal	271	14.41	$762.01	$368.38	$152.40
28113	T	Part removal of metatarsal	271	14.41	$762.01	$368.38	$152.40
28114	T	Removal of metatarsal heads	271	14.41	$762.01	$368.38	$152.40
28116	T	Revision of foot	271	14.41	$762.01	$368.38	$152.40
28118	T	Removal of heel bone	271	14.41	$762.01	$368.38	$152.40
28119	T	Removal of heel spur	271	14.41	$762.01	$368.38	$152.40
28120	T	Part removal of ankle/heel	271	14.41	$762.01	$368.38	$152.40
28122	T	Partial removal of foot bone	271	14.41	$762.01	$368.38	$152.40
28124	T	Partial removal of toe	271	14.41	$762.01	$368.38	$152.40
28126	T	Partial removal of toe	271	14.41	$762.01	$368.38	$152.40
28130	T	Removal of ankle bone	271	14.41	$762.01	$368.38	$152.40
28140	T	Removal of metatarsal	271	14.41	$762.01	$368.38	$152.40

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
28150	T	Removal of toe	271	14.41	$762.01	$368.38	$152.40
28153	T	Partial removal of toe	271	14.41	$762.01	$368.38	$152.40
28160	T	Partial removal of toe	271	14.41	$762.01	$368.38	$152.40
28171	T	Extensive foot surgery	271	14.41	$762.01	$368.38	$152.40
28173	T	Extensive foot surgery	271	14.41	$762.01	$368.38	$152.40
28175	T	Extensive foot surgery	271	14.41	$762.01	$368.38	$152.40
28190	T	Removal of foot foreign body	161	3.50	$185.12	$75.48	$37.02
28192	T	Removal of foot foreign body	163	10.69	$565.14	$264.65	$113.03
28193	T	Removal of foot foreign body	163	10.69	$565.14	$264.65	$113.03
28200	T	Repair of foot tendon	271	14.41	$762.01	$368.38	$152.40
28202	T	Repair/graft of foot tendon	272	16.56	$875.63	$409.74	$175.13
28208	T	Repair of foot tendon	271	14.41	$762.01	$368.38	$152.40
28210	T	Repair/graft of foot tendon	271	14.41	$762.01	$368.38	$152.40
28220	T	Release of foot tendon	271	14.41	$762.01	$368.38	$152.40
28222	T	Release of foot tendons	271	14.41	$762.01	$368.38	$152.40
28225	T	Release of foot tendon	271	14.41	$762.01	$368.38	$152.40
28226	T	Release of foot tendons	271	14.41	$762.01	$368.38	$152.40
28230	T	Incision of foot tendon(s)	271	14.41	$762.01	$368.38	$152.40
28232	T	Incision of toe tendon	271	14.41	$762.01	$368.38	$152.40
28234	T	Incision of foot tendon	271	14.41	$762.01	$368.38	$152.40
28238	T	Revision of foot tendon	272	16.56	$875.63	$409.74	$175.13
28240	T	Release of big toe	271	14.41	$762.01	$368.38	$152.40
28250	T	Revision of foot fascia	272	16.56	$875.63	$409.74	$175.13
28260	T	Release of midfoot joint	272	16.56	$875.63	$409.74	$175.13
28261	T	Revision of foot tendon	272	16.56	$875.63	$409.74	$175.13
28262	T	Revision of foot and ankle	272	16.56	$875.63	$409.74	$175.13
28264	T	Release of midfoot joint	272	16.56	$875.63	$409.74	$175.13
28270	T	Release of foot contracture	271	14.41	$762.01	$368.38	$152.40
28272	T	Release of toe joint, each	271	14.41	$762.01	$368.38	$152.40
28280	T	Fusion of toes	271	14.41	$762.01	$368.38	$152.40
28285	T	Repair of hammertoe	271	14.41	$762.01	$368.38	$152.40
28286	T	Repair of hammertoe	271	14.41	$762.01	$368.38	$152.40
28288	T	Partial removal of foot bone	272	16.56	$875.63	$409.74	$175.13
28290	T	Correction of bunion	276	19.19	$1,014.71	$500.14	$202.94
28292	T	Correction of bunion	276	19.19	$1,014.71	$500.14	$202.94
28293	T	Correction of bunion	276	19.19	$1,014.71	$500.14	$202.94
28294	T	Correction of bunion	276	19.19	$1,014.71	$500.14	$202.94
28296	T	Correction of bunion	276	19.19	$1,014.71	$500.14	$202.94
28297	T	Correction of bunion	276	19.19	$1,014.71	$500.14	$202.94
28298	T	Correction of bunion	276	19.19	$1,014.71	$500.14	$202.94
28299	T	Correction of bunion	276	19.19	$1,014.71	$500.14	$202.94
28300	T	Incision of heel bone	272	16.56	$875.63	$409.74	$175.13
28302	T	Incision of ankle bone	272	16.56	$875.63	$409.74	$175.13
28304	T	Incision of midfoot bones	272	16.56	$875.63	$409.74	$175.13
28305	T	Incise/graft midfoot bones	272	16.56	$875.63	$409.74	$175.13
28306	T	Incision of metatarsal	272	16.56	$875.63	$409.74	$175.13
28307	T	Incision of metatarsal	272	16.56	$875.63	$409.74	$175.13
28308	T	Incision of metatarsal	272	16.56	$875.63	$409.74	$175.13
28309	T	Incision of metatarsals	272	16.56	$875.63	$409.74	$175.13
28310	T	Revision of big toe	271	14.41	$762.01	$368.38	$152.40
28312	T	Revision of toe	271	14.41	$762.01	$368.38	$152.40
28313	T	Repair deformity of toe	271	14.41	$762.01	$368.38	$152.40
28315	T	Removal of sesamoid bone	271	14.41	$762.01	$368.38	$152.40
28320	T	Repair of foot bones	272	16.56	$875.63	$409.74	$175.13
28322	T	Repair of metatarsals	272	16.56	$875.63	$409.74	$175.13
28340	T	Resect enlarged toe tissue	271	14.41	$762.01	$368.38	$152.40
28341	T	Resect enlarged toe	271	14.41	$762.01	$368.38	$152.40
28344	T	Repair extra toe(s)	272	16.56	$875.63	$409.74	$175.13
28345	T	Repair webbed toe(s)	272	16.56	$875.63	$409.74	$175.13
28360	T	Reconstruct cleft foot	272	16.56	$875.63	$409.74	$175.13
28400	T	Treatment of heel fracture	209	1.94	$102.84	$37.29	$20.57
28405	T	Treatment of heel fracture	209	1.94	$102.84	$37.29	$20.57
28406	T	Treatment of heel fracture	216	20.13	$1,064.67	$520.93	$212.93
28415	T	Repair of heel fracture	216	20.13	$1,064.67	$520.93	$212.93
28420	T	Repair/graft heel fracture	216	20.13	$1,064.67	$520.93	$212.93
28430	T	Treatment of ankle fracture	209	1.94	$102.84	$37.29	$20.57
28435	T	Treatment of ankle fracture	209	1.94	$102.84	$37.29	$20.57
28436	T	Treatment of ankle fracture	216	20.13	$1,064.67	$520.93	$212.93
28445	T	Repair of ankle fracture	216	20.13	$1,064.67	$520.93	$212.93
28450	T	Treat midfoot fracture, each	209	1.94	$102.84	$37.29	$20.57
28455	T	Treat midfoot fracture, each	209	1.94	$102.84	$37.29	$20.57
28456	T	Repair midfoot fracture	216	20.13	$1,064.67	$520.93	$212.93
28465	T	Repair midfoot fracture, each	216	20.13	$1,064.67	$520.93	$212.93
28470	T	Treat metatarsal fracture	209	1.94	$102.84	$37.29	$20.57
28475	T	Treat metatarsal fracture	209	1.94	$102.84	$37.29	$20.57

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
28476	T	Repair metatarsal fracture	216	20.13	$1,064.67	$520.93	$212.93
28485	T	Repair metatarsal fracture	216	20.13	$1,064.67	$520.93	$212.93
28490	T	Treat big toe fracture	207	1.70	$90.11	$31.64	$18.02
28495	T	Treat big toe fracture	207	1.70	$90.11	$31.64	$18.02
28496	T	Repair big toe fracture	216	20.13	$1,064.67	$520.93	$212.93
28505	T	Repair big toe fracture	216	20.13	$1,064.67	$520.93	$212.93
28510	T	Treatment of toe fracture	207	1.70	$90.11	$31.64	$18.02
28515	T	Treatment of toe fracture	207	1.70	$90.11	$31.64	$18.02
28525	T	Repair of toe fracture	216	20.13	$1,064.67	$520.93	$212.93
28530	T	Treat sesamoid bone fracture	209	1.94	$102.84	$37.29	$20.57
28531	T	Treat sesamoid bone fracture	216	20.13	$1,064.67	$520.93	$212.93
28540	T	Treat foot dislocation	209	1.94	$102.84	$37.29	$20.57
28545	T	Treat foot dislocation	210	10.46	$553.39	$283.40	$110.68
28546	T	Treat foot dislocation	216	20.13	$1,064.67	$520.93	$212.93
28555	T	Repair foot dislocation	216	20.13	$1,064.67	$520.93	$212.93
28570	T	Treat foot dislocation	209	1.94	$102.84	$37.29	$20.57
28575	T	Treat foot dislocation	210	10.46	$553.39	$283.40	$110.68
28576	T	Treat foot dislocation	216	20.13	$1,064.67	$520.93	$212.93
28585	T	Repair foot dislocation	216	20.13	$1,064.67	$520.93	$212.93
28600	T	Treat foot dislocation	209	1.94	$102.84	$37.29	$20.57
28605	T	Treat foot dislocation	210	10.46	$553.39	$283.40	$110.68
28606	T	Treat foot dislocation	216	20.13	$1,064.67	$520.93	$212.93
28615	T	Repair foot dislocation	216	20.13	$1,064.67	$520.93	$212.93
28630	T	Treat toe dislocation	207	1.70	$90.11	$31.64	$18.02
28635	T	Treat toe dislocation	210	10.46	$553.39	$283.40	$110.68
28636	T	Treat toe dislocation	216	20.13	$1,064.67	$520.93	$212.93
28645	T	Repair toe dislocation	216	20.13	$1,064.67	$520.93	$212.93
28660	T	Treat toe dislocation	207	1.70	$90.11	$31.64	$18.02
28665	T	Treat toe dislocation	210	10.46	$553.39	$283.40	$110.68
28666	T	Treat toe dislocation	216	20.13	$1,064.67	$520.93	$212.93
28675	T	Repair of toe dislocation	216	20.13	$1,064.67	$520.93	$212.93
28705	T	Fusion of foot bones	272	16.56	$875.63	$409.74	$175.13
28715	T	Fusion of foot bones	272	16.56	$875.63	$409.74	$175.13
28725	T	Fusion of foot bones	272	16.56	$875.63	$409.74	$175.13
28730	T	Fusion of foot bones	272	16.56	$875.63	$409.74	$175.13
28735	T	Fusion of foot bones	272	16.56	$875.63	$409.74	$175.13
28737	T	Revision of foot bones	271	14.41	$762.01	$368.38	$152.40
28740	T	Fusion of foot bones	272	16.56	$875.63	$409.74	$175.13
28750	T	Fusion of big toe joint	271	14.41	$762.01	$368.38	$152.40
28755	T	Fusion of big toe joint	271	14.41	$762.01	$368.38	$152.40
28760	T	Fusion of big toe joint	272	16.56	$875.63	$409.74	$175.13
28800	C	Amputation of midfoot					
28805	C	Amputation thru metatarsal					
28810	T	Amputation toe & metatarsal	271	14.41	$762.01	$368.38	$152.40
28820	T	Amputation of toe	271	14.41	$762.01	$368.38	$152.40
28825	T	Partial amputation of toe	271	14.41	$762.01	$368.38	$152.40
28899	T	Foot/toes surgery procedure	207	1.70	$90.11	$31.64	$18.02
29000	N	Application of body cast					
29010	N	Application of body cast					
29015	N	Application of body cast					
29020	N	Application of body cast					
29025	N	Application of body cast					
29035	N	Application of body cast					
29040	N	Application of body cast					
29044	N	Application of body cast					
29046	N	Application of body cast					
29049	N	Application of figure eight					
29055	N	Application of shoulder cast					
29058	N	Application of shoulder cast					
29065	N	Application of long arm cast					
29075	N	Application of forearm cast					
29085	N	Apply hand/wrist cast					
29105	N	Apply long arm splint					
29125	N	Apply forearm splint					
29126	N	Apply forearm splint					
29130	N	Application of finger splint					
29131	N	Application of finger splint					
29200	N	Strapping of chest					
29220	N	Strapping of low back					
29240	N	Strapping of shoulder					
29260	N	Strapping of elbow or wrist					
29280	N	Strapping of hand or finger					
29305	N	Application of hip cast					
29325	N	Application of hip casts					
29345	N	Application of long leg cast					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
29355	N	Application of long leg cast	.....	.....	.....	.....	.....
29358	N	Apply long leg cast brace	.....	.....	.....	.....	.....
29365	N	Application of long leg cast	.....	.....	.....	.....	.....
29405	N	Apply short leg cast	.....	.....	.....	.....	.....
29425	N	Apply short leg cast	.....	.....	.....	.....	.....
29435	N	Apply short leg cast	.....	.....	.....	.....	.....
29440	N	Addition of walker to cast	.....	.....	.....	.....	.....
29445	N	Apply rigid leg cast	.....	.....	.....	.....	.....
29450	N	Application of leg cast	.....	.....	.....	.....	.....
29505	N	Application long leg splint	.....	.....	.....	.....	.....
29515	N	Application lower leg splint	.....	.....	.....	.....	.....
29520	N	Strapping of hip	.....	.....	.....	.....	.....
29530	N	Strapping of knee	.....	.....	.....	.....	.....
29540	N	Strapping of ankle	.....	.....	.....	.....	.....
29550	N	Strapping of toes	.....	.....	.....	.....	.....
29580	N	Application of paste boot	.....	.....	.....	.....	.....
29590	N	Application of foot splint	.....	.....	.....	.....	.....
29700	N	Removal/revision of cast	.....	.....	.....	.....	.....
29705	N	Removal/revision of cast	.....	.....	.....	.....	.....
29710	N	Removal/revision of cast	.....	.....	.....	.....	.....
29715	N	Removal/revision of cast	.....	.....	.....	.....	.....
29720	N	Repair of body cast	.....	.....	.....	.....	.....
29730	N	Windowing of cast	.....	.....	.....	.....	.....
29740	N	Wedging of cast	.....	.....	.....	.....	.....
29750	N	Wedging of clubfoot cast	.....	.....	.....	.....	.....
29799	N	Casting/strapping procedure	.....	.....	.....	.....	.....
29800	T	Jaw arthroscopy/surgery	280	22.20	$1,174.36	$581.72	$234.87
29804	T	Jaw arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29815	T	Shoulder arthroscopy	280	22.20	$1,174.36	$581.72	$234.87
29819	T	Shoulder arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29820	T	Shoulder arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29821	T	Shoulder arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29822	T	Shoulder arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29823	T	Shoulder arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29825	T	Shoulder arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29826	T	Shoulder arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29830	T	Elbow arthroscopy	280	22.20	$1,174.36	$581.72	$234.87
29834	T	Elbow arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29835	T	Elbow arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29836	T	Elbow arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29837	T	Elbow arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29838	T	Elbow arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29840	T	Wrist arthroscopy	280	22.20	$1,174.36	$581.72	$234.87
29843	T	Wrist arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29844	T	Wrist arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29845	T	Wrist arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29846	T	Wrist arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29847	T	Wrist arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29848	T	Wrist arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29850	T	Knee arthroscopy/surgery	286	26.76	$1,415.31	$802.53	$283.06
29851	T	Knee arthroscopy/surgery	286	26.76	$1,415.31	$802.53	$283.06
29855	T	Tibial arthroscopy/surgery	286	26.76	$1,415.31	$802.53	$283.06
29856	T	Tibial arthroscopy/surgery	286	26.76	$1,415.31	$802.53	$283.06
29860	T	Hip arthroscopy, dx	281	22.65	$1,197.87	$590.31	$239.57
29861	T	Hip arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29862	T	Hip arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29863	T	Hip arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29870	T	Knee arthroscopy, diagnostic	280	22.20	$1,174.36	$581.72	$234.87
29871	T	Knee arthroscopy/drainage	282	23.94	$1,266.43	$614.04	$253.29
29874	T	Knee arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29875	T	Knee arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29876	T	Knee arthroscopy/surgery	282	23.94	$1,266.43	$614.04	$253.29
29877	T	Knee arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29879	T	Knee arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29880	T	Knee arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29881	T	Knee arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29882	T	Knee arthroscopy/surgery	282	23.94	$1,266.43	$614.04	$253.29
29883	T	Knee arthroscopy/surgery	282	23.94	$1,266.43	$614.04	$253.29
29884	T	Knee arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29885	T	Knee arthroscopy/surgery	282	23.94	$1,266.43	$614.04	$253.29
29886	T	Knee arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29887	T	Knee arthroscopy/surgery	282	23.94	$1,266.43	$614.04	$253.29
29888	T	Knee arthroscopy/surgery	286	26.76	$1,415.31	$802.53	$283.06
29889	T	Knee arthroscopy/surgery	286	26.76	$1,415.31	$802.53	$283.06
29891	T	Ankle arthroscopy/surgery	282	23.94	$1,266.43	$614.04	$253.29

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
29892	T	Ankle arthroscopy/surgery	286	26.76	$1,415.31	$802.53	$283.06
29893	T	Scope, plantar fasciotomy	271	14.41	$762.01	$368.38	$152.40
29894	T	Ankle arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29895	T	Ankle arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29897	T	Ankle arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29898	T	Ankle arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29909	T	Arthroscopy of joint	280	22.20	$1,174.36	$581.72	$234.87
30000	T	Drainage of nose lesion	311	1.43	$75.42	$20.57	$15.08
30020	T	Drainage of nose lesion	311	1.43	$75.42	$20.57	$15.08
30100	T	Intranasal biopsy	311	1.43	$75.42	$20.57	$15.08
30110	T	Removal of nose polyp(s)	311	1.43	$75.42	$20.57	$15.08
30115	T	Removal of nose polyp(s)	313	15.81	$836.45	$411.09	$167.29
30117	T	Removal of intranasal lesion	311	1.43	$75.42	$20.57	$15.08
30118	T	Removal of intranasal lesion	313	15.81	$836.45	$411.09	$167.29
30120	T	Revision of nose	313	15.81	$836.45	$411.09	$167.29
30124	T	Removal of nose lesion	311	1.43	$75.42	$20.57	$15.08
30125	T	Removal of nose lesion	313	15.81	$836.45	$411.09	$167.29
30130	T	Removal of turbinate bones	313	15.81	$836.45	$411.09	$167.29
30140	T	Removal of turbinate bones	313	15.81	$836.45	$411.09	$167.29
30150	T	Partial removal of nose	313	15.81	$836.45	$411.09	$167.29
30160	T	Removal of nose	313	15.81	$836.45	$411.09	$167.29
30200	T	Injection treatment of nose	347	2.93	$154.75	$62.15	$30.95
30210	T	Nasal sinus therapy	311	1.43	$75.42	$20.57	$15.08
30220	T	Insert nasal septal button	311	1.43	$75.42	$20.57	$15.08
30300	T	Remove nasal foreign body	311	1.43	$75.42	$20.57	$15.08
30310	T	Remove nasal foreign body	313	15.81	$836.45	$411.09	$167.29
30320	T	Remove nasal foreign body	313	15.81	$836.45	$411.09	$167.29
30400	T	Reconstruction of nose	314	25.65	$1,356.54	$693.37	$271.31
30410	T	Reconstruction of nose	314	25.65	$1,356.54	$693.37	$271.31
30420	T	Reconstruction of nose	314	25.65	$1,356.54	$693.37	$271.31
30430	T	Revision of nose	313	15.81	$836.45	$411.09	$167.29
30435	T	Revision of nose	314	25.65	$1,356.54	$693.37	$271.31
30450	T	Revision of nose	314	25.65	$1,356.54	$693.37	$271.31
30460	T	Revision of nose	314	25.65	$1,356.54	$693.37	$271.31
30462	T	Revision of nose	314	25.65	$1,356.54	$693.37	$271.31
30520	T	Repair of nasal septum	313	15.81	$836.45	$411.09	$167.29
30540	T	Repair nasal defect	313	15.81	$836.45	$411.09	$167.29
30545	T	Repair nasal defect	314	25.65	$1,356.54	$693.37	$271.31
30560	T	Release of nasal adhesions	311	1.43	$75.42	$20.57	$15.08
30580	T	Repair upper jaw fistula	313	15.81	$836.45	$411.09	$167.29
30600	T	Repair mouth/nose fistula	313	15.81	$836.45	$411.09	$167.29
30620	T	Intranasal reconstruction	313	15.81	$836.45	$411.09	$167.29
30630	T	Repair nasal septum defect	313	15.81	$836.45	$411.09	$167.29
30801	T	Cauterization inner nose	312	7.26	$383.95	$178.31	$76.79
30802	T	Cauterization inner nose	312	7.26	$383.95	$178.31	$76.79
30901	T	Control of nosebleed	318	2.07	$109.70	$38.65	$21.94
30903	T	Control of nosebleed	318	2.07	109.70	$38.65	$21.94
30905	T	Control of nosebleed	318	2.07	$109.70	$38.65	$21.94
30906	T	Repeat control of nosebleed	318	2.07	$109.70	$38.65	$21.94
30915	T	Ligation nasal sinus artery	367	17.59	$930.48	$449.06	$186.10
30920	T	Ligation upper jaw artery	367	17.59	$930.48	$449.06	$186.10
30930	T	Therapy fracture of nose	312	7.26	$383.95	$178.31	$76.79
30999	T	Nasal surgery procedure	318	2.07	$109.70	$38.65	$21.94
31000	T	Irrigation maxillary sinus	311	1.43	$75.42	$20.57	$15.08
31002	T	Irrigation sphenoid sinus	311	1.43	$75.42	$20.57	$15.08
31020	T	Exploration maxillary sinus	313	15.81	$836.45	$411.09	$167.29
31030	T	Exploration maxillary sinus	313	15.81	$836.45	$411.09	$167.29
31032	T	Explore sinus, remove polyps	313	15.81	$836.45	$411.09	$167.29
31040	T	Exploration behind upper jaw	314	25.65	$1,356.54	$693.37	$271.31
31050	T	Exploration sphenoid sinus	313	15.81	$836.45	$411.09	$167.29
31051	T	Sphenoid sinus surgery	313	15.81	$836.45	$411.09	$167.29
31070	T	Exploration of frontal sinus	313	15.81	$836.45	$411.09	$167.29
31075	T	Exploration of frontal sinus	314	25.65	$1,356.54	$693.37	$271.31
31080	T	Removal of frontal sinus	314	25.65	$1,356.54	$693.37	$271.31
31081	T	Removal of frontal sinus	314	25.65	$1,356.54	$693.37	$271.31
31084	T	Removal of frontal sinus	314	25.65	$1,356.54	$693.37	$271.31
31085	T	Removal of frontal sinus	314	25.65	$1,356.54	$693.37	$271.31
31086	T	Removal of frontal sinus	314	25.65	$1,356.54	$693.37	$271.31
31087	T	Removal of frontal sinus	314	25.65	$1,356.54	$693.37	$271.31
31090	T	Exploration of sinuses	314	25.65	$1,356.54	$693.37	$271.31
31200	T	Removal of ethmoid sinus	313	15.81	$836.45	$411.09	$167.29
31201	T	Removal of ethmoid sinus	314	25.65	$1,356.54	$693.37	$271.31
31205	T	Removal of ethmoid sinus	314	25.65	$1,356.54	$693.37	$271.31
31225	C	Removal of upper jaw	.....	.....	.....	.....	.....
31230	C	Removal of upper jaw	.....	.....	.....	.....	.....

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
31231	T	Nasal endoscopy, dx	331	0.69	$36.24	$14.01	$7.25
31233	T	Nasal/sinus endoscopy, dx	332	9.74	$515.19	$244.98	$103.04
31235	T	Nasal/sinus endoscopy, dx	332	9.74	$515.19	$244.98	$103.04
31237	T	Nasal/sinus endoscopy, surg	332	9.74	$515.19	$244.98	$103.04
31238	T	Nasal/sinus endoscopy, surg	332	9.74	$515.19	$244.98	$103.04
31239	T	Nasal/sinus endoscopy, surg	333	17.24	$911.87	$464.20	$182.37
31240	T	Nasal/sinus endoscopy, surg	332	9.74	$515.19	$244.98	$103.04
31254	T	Revision of ethmoid sinus	333	17.24	$911.87	$464.20	$182.37
31255	T	Removal of ethmoid sinus	333	17.24	$911.87	$464.20	$182.37
31256	T	Exploration maxillary sinus	333	17.24	$911.87	$464.20	$182.37
31267	T	Endoscopy, maxillary sinus	333	17.24	$911.87	$464.20	$182.37
31276	T	Sinus surgical endoscopy	333	17.24	$911.87	$464.20	$182.37
31287	T	Nasal/sinus endoscopy, surg	333	17.24	$911.87	$464.20	$182.37
31288	T	Nasal/sinus endoscopy, surg	333	17.24	$911.87	$464.20	$182.37
31290	C	Nasal/sinus endoscopy, surg					
31291	C	Nasal/sinus endoscopy, surg					
31292	C	Nasal/sinus endoscopy, surg					
31293	C	Nasal/sinus endoscopy, surg					
31294	C	Nasal/sinus endoscopy, surg					
31299	T	Sinus surgery procedure	331	0.69	$36.24	$14.01	$7.25
31300	T	Removal of larynx lesion	314	25.65	$1,356.54	$693.37	$271.31
31320	T	Diagnostic incision larynx	313	15.81	$836.45	$411.09	$167.29
31360	C	Removal of larynx					
31365	C	Removal of larynx					
31367	C	Partial removal of larynx					
31368	C	Partial removal of larynx					
31370	C	Partial removal of larynx					
31375	C	Partial removal of larynx					
31380	C	Partial removal of larynx					
31382	C	Partial removal of larynx					
31390	C	Removal of larynx & pharynx					
31395	C	Reconstruct larynx & pharynx					
31400	T	Revision of larynx	314	25.65	$1,356.54	$693.37	$271.31
31420	T	Removal of epiglottis	314	25.65	$1,356.54	$693.37	$271.31
31500	S	Insert emergency airway	947	4.07	$215.48	$109.61	$43.10
31502	T	Change of windpipe airway	470	2.22	$117.53	$54.92	$23.51
31505	T	Diagnostic laryngoscopy	331	0.69	$36.24	$14.01	$7.25
31510	T	Laryngoscopy with biopsy	332	9.74	$515.19	$244.98	$103.04
31511	T	Remove foreign body, larynx	332	9.74	$515.19	$244.98	$103.04
31512	T	Removal of larynx lesion	332	9.74	$515.19	$244.98	$103.04
31513	T	Injection into vocal cord	332	9.74	$515.19	$244.98	$103.04
31515	T	Laryngoscopy for aspiration	332	9.74	$515.19	$244.98	$103.04
31520	T	Diagnostic laryngoscopy	332	9.74	$515.19	$244.98	$103.04
31525	T	Diagnostic laryngoscopy	332	9.74	$515.19	$244.98	$103.04
31526	T	Diagnostic laryngoscopy	332	9.74	$515.19	$244.98	$103.04
31527	T	Laryngoscopy for treatment	333	17.24	$911.87	$464.20	$182.37
31528	T	Laryngoscopy and dilatation	332	9.74	$515.19	$244.98	$103.04
31529	T	Laryngoscopy and dilatation	332	9.74	$515.19	$244.98	$103.04
31530	T	Operative laryngoscopy	333	17.24	$911.87	$464.20	$182.37
31531	T	Operative laryngoscopy	333	17.24	$911.87	$464.20	$182.37
31535	T	Operative laryngoscopy	333	17.24	$911.87	$464.20	$182.37
31536	T	Operative laryngoscopy	333	17.24	$911.87	$464.20	$182.37
31540	T	Operative laryngoscopy	333	17.24	$911.87	$464.20	$182.37
31541	T	Operative laryngoscopy	333	17.24	$911.87	$464.20	$182.37
31560	T	Operative laryngoscopy	333	17.24	$911.87	$464.20	$182.37
31561	T	Operative laryngoscopy	333	17.24	$911.87	$464.20	$182.37
31570	T	Laryngoscopy with injection	333	17.24	$911.87	$464.20	$182.37
31571	T	Laryngoscopy with injection	333	17.24	$911.87	$464.20	$182.37
31575	T	Diagnostic laryngoscopy	331	0.69	$36.24	$14.01	$7.25
31576	T	Laryngoscopy with biopsy	332	9.74	$515.19	$244.98	$103.04
31577	T	Remove foreign body, larynx	332	9.74	$515.19	$244.98	$103.04
31578	T	Removal of larynx lesion	332	9.74	$515.19	$244.98	$103.04
31579	T	Diagnostic laryngoscopy	331	0.69	$36.24	$14.01	$7.25
31580	C	Revision of larynx					
31582	C	Revision of larynx					
31584	C	Repair of larynx fracture					
31585	T	Repair of larynx fracture	207	1.70	$90.11	$31.64	$18.02
31586	T	Repair of larynx fracture	209	1.94	$102.84	$37.29	$20.57
31587	C	Revision of larynx					
31588	T	Revision of larynx	314	25.65	$1,356.54	$693.37	$271.31
31590	T	Reinnervate larynx	314	25.65	$1,356.54	$693.37	$271.31
31595	T	Larynx nerve surgery	313	15.81	$836.45	$411.09	$167.29
31599	T	Larynx surgery procedure	207	1.70	$90.11	$31.64	$18.02
31600	C	Incision of windpipe					
31601	C	Incision of windpipe					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
31603	T	Incision of windpipe	311	1.43	$75.42	$20.57	$15.08
31605	T	Incision of windpipe	311	1.43	$75.42	$20.57	$15.08
31610	C	Incision of windpipe					
31611	T	Surgery/speech prosthesis	313	15.81	$836.45	$411.09	$167.29
31612	T	Puncture/clear windpipe	312	7.26	$383.95	$178.31	$76.79
31613	T	Repair windpipe opening	313	15.81	$836.45	$411.09	$167.29
31614	T	Repair windpipe opening	313	15.81	$836.45	$411.09	$167.29
31615	T	Visualization of windpipe	336	7.44	$393.74	$197.98	$78.75
31622	T	Diagnostic bronchoscopy	336	7.44	$393.74	$197.98	$78.75
31625	T	Bronchoscopy with biopsy	336	7.44	$393.74	$197.98	$78.75
31628	T	Bronchoscopy with biopsy	336	7.44	$393.74	$197.98	$78.75
31629	T	Bronchoscopy with biopsy	336	7.44	$393.74	$197.98	$78.75
31630	T	Bronchoscopy with repair	336	7.44	$393.74	$197.98	$78.75
31631	T	Bronchoscopy with dilation	336	7.44	$393.74	$197.98	$78.75
31635	T	Remove foreign body, airway	336	7.44	$393.74	$197.98	$78.75
31640	T	Bronchoscopy & remove lesion	336	7.44	$393.74	$197.98	$78.75
31641	T	Bronchoscopy, treat blockage	336	7.44	$393.74	$197.98	$78.75
31645	T	Bronchoscopy, clear airways	336	7.44	$393.74	$197.98	$78.75
31646	T	Bronchoscopy, reclear airways	336	7.44	$393.74	$197.98	$78.75
31656	T	Bronchoscopy, inject for xray	336	7.44	$393.74	$197.98	$78.75
31700	T	Insertion of airway catheter	332	9.74	$515.19	$244.98	$103.04
31708	T	Instill airway contrast dye	347	2.93	$154.75	$62.15	$30.95
31710	T	Insertion of airway catheter	347	2.93	$154.75	$62.15	$30.95
31715	T	Injection for bronchus x-ray	347	2.93	$154.75	$62.15	$30.95
31717	T	Bronchial brush biopsy	332	9.74	$515.19	$244.98	$103.04
31720	T	Clearance of airways	332	9.74	$515.19	$244.98	$103.04
31725	C	Clearance of airways					
31730	T	Intro windpipe wire/tube	332	9.74	$515.19	$244.98	$103.04
31750	T	Repair of windpipe	314	25.65	$1,356.54	$693.37	$271.31
31755	T	Repair of windpipe	314	25.65	$1,356.54	$693.37	$271.31
31760	C	Repair of windpipe					
31766	C	Reconstruction of windpipe					
31770	C	Repair/graft of bronchus					
31775	C	Reconstruct bronchus					
31780	C	Reconstruct windpipe					
31781	C	Reconstruct windpipe					
31785	C	Remove windpipe lesion					
31786	C	Remove windpipe lesion					
31800	C	Repair of windpipe injury					
31805	C	Repair of windpipe injury					
31820	T	Closure of windpipe lesion	313	15.81	$836.45	$411.09	$167.29
31825	T	Repair of windpipe defect	313	15.81	$836.45	$411.09	$167.29
31830	T	Revise windpipe scar	313	15.81	$836.45	$411.09	$167.29
31899	T	Airways surgical procedure	336	7.44	$393.74	$197.98	$78.75
32000	T	Drainage of chest	320	3.17	$167.49	$79.33	$33.50
32002	T	Treatment of collapsed lung	320	3.17	$167.49	$79.33	$33.50
32005	C	Treat lung lining chemically					
32020	T	Insertion of chest tube	320	3.17	$167.49	$79.33	$33.50
32035	C	Exploration of chest					
32036	C	Exploration of chest					
32095	C	Biopsy through chest wall					
32100	C	Exploration/biopsy of chest					
32110	C	Explore/repair chest					
32120	C	Re-exploration of chest					
32124	C	Explore chest, free adhesions					
32140	C	Removal of lung lesion(s)					
32141	C	Remove/treat lung lesions					
32150	C	Removal of lung lesion(s)					
32151	C	Remove lung foreign body					
32160	C	Open chest heart massage					
32200	C	Open drainage, lung lesion					
32201	C	Percut drainage, lung lesion					
32215	C	Treat chest lining					
32220	C	Release of lung					
32225	C	Partial release of lung					
32310	C	Removal of chest lining					
32320	C	Free/remove chest lining					
32400	T	Needle biopsy chest lining	122	4.87	$257.60	$115.03	$51.52
32402	C	Open biopsy chest lining					
32405	T	Biopsy, lung or mediastinum	122	4.87	$257.60	$115.03	$51.52
32420	T	Puncture/clear lung	320	3.17	$167.49	$79.33	$33.50
32440	C	Removal of lung					
32442	C	Sleeve pneumonectomy					
32445	C	Removal of lung					
32480	C	Partial removal of lung					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
32482	C	Bilobectomy					
32484	C	Segmentectomy					
32486	C	Sleeve lobectomy					
32488	C	Completion pneumonectomy					
32491	C	Lung volume reduction					
32500	C	Partial removal of lung					
32501	C	Repair bronchus (add-on)					
32520	C	Remove lung & revise chest					
32522	C	Remove lung & revise chest					
32525	C	Remove lung & revise chest					
32540	C	Removal of lung lesion					
32601	C	Thoracoscopy, diagnostic					
32602	C	Thoracoscopy, diagnostic					
32603	C	Thoracoscopy, diagnostic					
32604	C	Thoracoscopy, diagnostic					
32605	C	Thoracoscopy, diagnostic					
32606	C	Thoracoscopy, diagnostic					
32650	C	Thoracoscopy, surgical					
32651	C	Thoracoscopy, surgical					
32652	C	Thoracoscopy, surgical					
32653	C	Thoracoscopy, surgical					
32654	C	Thoracoscopy, surgical					
32655	C	Thoracoscopy, surgical					
32656	C	Thoracoscopy, surgical					
32657	C	Thoracoscopy, surgical					
32658	C	Thoracoscopy, surgical					
32659	C	Thoracoscopy, surgical					
32660	C	Thoracoscopy, surgical					
32661	C	Thoracoscopy, surgical					
32662	C	Thoracoscopy, surgical					
32663	C	Thoracoscopy, surgical					
32664	C	Thoracoscopy, surgical					
32665	C	Thoracoscopy, surgical					
32800	C	Repair lung hernia					
32810	C	Close chest after drainage					
32815	C	Close bronchial fistula					
32820	C	Reconstruct injured chest					
32850	C	Donor pneumonectomy					
32851	C	Lung transplant, single					
32852	C	Lung transplant w/bypass					
32853	C	Lung transplant, double					
32854	C	Lung transplant w/bypass					
32900	C	Removal of rib(s)					
32905	C	Revise & repair chest wall					
32906	C	Revise & repair chest wall					
32940	C	Revision of lung					
32960	T	Therapeutic pneumothorax	320	3.17	$167.49	$79.33	$33.50
32999	T	Chest surgery procedure	320	3.17	$167.49	$79.33	$33.50
33010	T	Drainage of heart sac	320	3.17	$167.49	$79.33	$33.50
33011	T	Repeat drainage of heart sac	320	3.17	$167.49	$79.33	$33.50
33015	C	Incision of heart sac					
33020	C	Incision of heart sac					
33025	C	Incision of heart sac					
33030	C	Partial removal of heart sac					
33031	C	Partial removal of heart sac					
33050	C	Removal of heart sac lesion					
33120	C	Removal of heart lesion					
33130	C	Removal of heart lesion					
33200	C	Insertion of heart pacemaker					
33201	C	Insertion of heart pacemaker					
33206	C	Insertion of heart pacemaker					
33207	C	Insertion of heart pacemaker					
33208	C	Insertion of heart pacemaker					
33210	C	Insertion of heart electrode					
33211	C	Insertion of heart electrode					
33212	C	Insertion of pulse generator					
33213	C	Insertion of pulse generator					
33214	C	Upgrade of pacemaker system					
33216	C	Revision implanted electrode					
33217	C	Insert/revise electrode					
33218	C	Repair pacemaker electrodes					
33220	C	Repair pacemaker electrode					
33222	T	Pacemaker AICD pocket	360	6.09	$322.24	$140.12	$64.45
33223	T	Pacemaker AICD pocket	360	6.09	$322.24	$140.12	$64.45
33233	C	Removal of pacemaker system					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
33234	C	Removal of pacemaker system					
33235	C	Removal pacemaker electrode					
33236	C	Remove electrode/thoracotomy					
33237	C	Remove electrode/thoracotomy					
33238	C	Remove electrode/thoracotomy					
33240	C	Insert/replace pulse gener					
33241	C	Remove pulse generator only					
33242	C	Repair pulse generator/leads					
33243	C	Remove generator/thoracotomy					
33244	C	Remove generator					
33245	C	Implant heart defibrillator					
33246	C	Implant heart defibrillator					
33247	C	Insert/replace leads					
33249	C	Insert/replace leads/gener					
33250	C	Ablate heart dysrhythm focus					
33251	C	Ablate heart dysrhythm focus					
33253	C	Reconstruct atria					
33261	C	Ablate heart dysrhythm focus					
33300	C	Repair of heart wound					
33305	C	Repair of heart wound					
33310	C	Exploratory heart surgery					
33315	C	Exploratory heart surgery					
33320	C	Repair major blood vessel(s)					
33321	C	Repair major vessel					
33322	C	Repair major blood vessel(s)					
33330	C	Insert major vessel graft					
33332	C	Insert major vessel graft					
33335	C	Insert major vessel graft					
33400	C	Repair of aortic valve					
33401	C	Valvuloplasty, open					
33403	C	Valvuloplasty, w/cp bypass					
33404	C	Prepare heart-aorta conduit					
33405	C	Replacement of aortic valve					
33406	C	Replacement, aortic valve					
33411	C	Replacement of aortic valve					
33412	C	Replacement of aortic valve					
33413	C	Replacement, aortic valve					
33414	C	Repair, aortic valve					
33415	C	Revision, subvalvular tissue					
33416	C	Revise ventricle muscle					
33417	C	Repair of aortic valve					
33420	C	Revision of mitral valve					
33422	C	Revision of mitral valve					
33425	C	Repair of mitral valve					
33426	C	Repair of mitral valve					
33427	C	Repair of mitral valve					
33430	C	Replacement of mitral valve					
33460	C	Revision of tricuspid valve					
33463	C	Valvuloplasty, tricuspid					
33464	C	Valvuloplasty, tricuspid					
33465	C	Replace tricuspid valve					
33468	C	Revision of tricuspid valve					
33470	C	Revision of pulmonary valve					
33471	C	Valvotomy, pulmonary valve					
33472	C	Revision of pulmonary valve					
33474	C	Revision of pulmonary valve					
33475	C	Replacement, pulmonary valve					
33476	C	Revision of heart chamber					
33478	C	Revision of heart chamber					
33496	C	Repair, prosth valve clot					
33500	C	Repair heart vessel fistula					
33501	C	Repair heart vessel fistula					
33502	C	Coronary artery correction					
33503	C	Coronary artery graft					
33504	C	Coronary artery graft					
33505	C	Repair artery w/tunnel					
33506	C	Repair artery, translocation					
33510	C	CABG, vein, single					
33511	C	CABG, vein, two					
33512	C	CABG, vein, three					
33513	C	CABG, vein, four					
33514	C	CABG, vein, five					
33516	C	CABG, vein, six+					
33517	C	CABG, artery-vein, single					
33518	C	CABG, artery-vein, two					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
33519	C	CABG, artery-vein, three					
33521	C	CABG, artery-vein, four					
33522	C	CABG, artery-vein, five					
33523	C	CABG, artery-vein, six+					
33530	C	Coronary artery, bypass/reop					
33533	C	CABG, arterial, single					
33534	C	CABG, arterial, two					
33535	C	CABG, arterial, three					
33536	C	CABG, arterial, four+					
33542	C	Removal of heart lesion					
33545	C	Repair of heart damage					
33572	C	Open coronary endarterectomy					
33600	C	Closure of valve					
33602	C	Closure of valve					
33606	C	Anastomosis/artery-aorta					
33608	C	Repair anomaly w/conduit					
33610	C	Repair by enlargement					
33611	C	Repair double ventricle					
33612	C	Repair double ventricle					
33615	C	Repair (simple fontan)					
33617	C	Repair by modified fontan					
33619	C	Repair single ventricle					
33641	C	Repair heart septum defect					
33645	C	Revision of heart veins					
33647	C	Repair heart septum defects					
33660	C	Repair of heart defects					
33665	C	Repair of heart defects					
33670	C	Repair of heart chambers					
33681	C	Repair heart septum defect					
33684	C	Repair heart septum defect					
33688	C	Repair heart septum defect					
33690	C	Reinforce pulmonary artery					
33692	C	Repair of heart defects					
33694	C	Repair of heart defects					
33697	C	Repair of heart defects					
33702	C	Repair of heart defects					
33710	C	Repair of heart defects					
33720	C	Repair of heart defect					
33722	C	Repair of heart defect					
33730	C	Repair heart-vein defect(s)					
33732	C	Repair heart-vein defect					
33735	C	Revision of heart chamber					
33736	C	Revision of heart chamber					
33737	C	Revision of heart chamber					
33750	C	Major vessel shunt					
33755	C	Major vessel shunt					
33762	C	Major vessel shunt					
33764	C	Major vessel shunt & graft					
33766	C	Major vessel shunt					
33767	C	Atrial septectomy/septostomy					
33770	C	Repair great vessels defect					
33771	C	Repair great vessels defect					
33774	C	Repair great vessels defect					
33775	C	Repair great vessels defect					
33776	C	Repair great vessels defect					
33777	C	Repair great vessels defect					
33778	C	Repair great vessels defect					
33779	C	Repair great vessels defect					
33780	C	Repair great vessels defect					
33781	C	Repair great vessels defect					
33786	C	Repair arterial trunk					
33788	C	Revision of pulmonary artery					
33800	C	Aortic suspension					
33802	C	Repair vessel defect					
33803	C	Repair vessel defect					
33813	C	Repair septal defect					
33814	C	Repair septal defect					
33820	C	Revise major vessel					
33822	C	Revise major vessel					
33824	C	Revise major vessel					
33840	C	Remove aorta constriction					
33845	C	Remove aorta constriction					
33851	C	Remove aorta constriction					
33852	C	Repair septal defect					
33853	C	Repair septal defect					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
33860	C	Ascending aorta graft					
33861	C	Ascending aorta graft					
33863	C	Ascending aorta graft					
33870	C	Transverse aortic arch graft					
33875	C	Thoracic aorta graft					
33877	C	Thoracoabdominal graft					
33910	C	Remove lung artery emboli					
33915	C	Remove lung artery emboli					
33916	C	Surgery of great vessel					
33917	C	Repair pulmonary artery					
33918	C	Repair pulmonary atresia					
33919	C	Repair pulmonary atresia					
33920	C	Repair pulmonary atresia					
33922	C	Transect pulmonary artery					
33924	C	Remove pulmonary shunt					
33930	C	Removal of donor heart/lung					
33935	C	Transplantation, heart/lung					
33940	C	Removal of donor heart					
33945	C	Transplantation of heart					
33960	C	External circulation assist					
33961	C	External circulation assist					
33970	C	Aortic circulation assist					
33971	C	Aortic circulation assist					
33973	C	Insert balloon device					
33974	C	Remove intra-aortic balloon					
33975	C	Implant ventricular device					
33976	C	Implant ventricular device					
33977	C	Remove ventricular device					
33978	C	Remove ventricular device					
33999	T	Cardiac surgery procedure	320	3.17	$167.49	$79.33	$33.50
34001	C	Removal of artery clot					
34051	C	Removal of artery clot					
34101	C	Removal of artery clot					
34111	C	Removal of arm artery clot					
34151	C	Removal of artery clot					
34201	C	Removal of artery clot					
34203	C	Removal of leg artery clot					
34401	C	Removal of vein clot					
34421	C	Removal of vein clot					
34451	C	Removal of vein clot					
34471	C	Removal of vein clot					
34490	C	Removal of vein clot					
34501	C	Repair valve, femoral vein					
34502	C	Reconstruct, vena cava					
34510	C	Transposition of vein valve					
34520	C	Cross-over vein graft					
34530	C	Leg vein fusion					
35001	C	Repair defect of artery					
35002	C	Repair artery rupture, neck					
35005	C	Repair defect of artery					
35011	C	Repair defect of artery					
35013	C	Repair artery rupture, arm					
35021	C	Repair defect of artery					
35022	C	Repair artery rupture, chest					
35045	C	Repair defect of arm artery					
35081	C	Repair defect of artery					
35082	C	Repair artery rupture, aorta					
35091	C	Repair defect of artery					
35092	C	Repair artery rupture, aorta					
35102	C	Repair defect of artery					
35103	C	Repair artery rupture, groin					
35111	C	Repair defect of artery					
35112	C	Repair artery rupture, spleen					
35121	C	Repair defect of artery					
35122	C	Repair artery rupture, belly					
35131	C	Repair defect of artery					
35132	C	Repair artery rupture, groin					
35141	C	Repair defect of artery					
35142	C	Repair artery rupture, thigh					
35151	C	Repair defect of artery					
35152	C	Repair artery rupture, knee					
35161	C	Repair defect of artery					
35162	C	Repair artery rupture					
35180	C	Repair blood vessel lesion					
35182	C	Repair blood vessel lesion					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
35184	C	Repair blood vessel lesion					
35188	T	Repair blood vessel lesion	368	22.83	$1,207.67	$648.85	$241.53
35189	C	Repair blood vessel lesion					
35190	C	Repair blood vessel lesion					
35201	C	Repair blood vessel lesion					
35206	C	Repair blood vessel lesion					
35207	T	Repair blood vessel lesion	368	22.83	$1,207.67	$648.85	$241.53
35211	C	Repair blood vessel lesion					
35216	C	Repair blood vessel lesion					
35221	C	Repair blood vessel lesion					
35226	C	Repair blood vessel lesion					
35231	C	Repair blood vessel lesion					
35236	C	Repair blood vessel lesion					
35241	C	Repair blood vessel lesion					
35246	C	Repair blood vessel lesion					
35251	C	Repair blood vessel lesion					
35256	C	Repair blood vessel lesion					
35261	C	Repair blood vessel lesion					
35266	C	Repair blood vessel lesion					
35271	C	Repair blood vessel lesion					
35276	C	Repair blood vessel lesion					
35281	C	Repair blood vessel lesion					
35286	C	Repair blood vessel lesion					
35301	C	Rechanneling of artery					
35311	C	Rechanneling of artery					
35321	C	Rechanneling of artery					
35331	C	Rechanneling of artery					
35341	C	Rechanneling of artery					
35351	C	Rechanneling of artery					
35355	C	Rechanneling of artery					
35361	C	Rechanneling of artery					
35363	C	Rechanneling of artery					
35371	C	Rechanneling of artery					
35372	C	Rechanneling of artery					
35381	C	Rechanneling of artery					
35390	C	Reoperation, carotid					
35400	C	Angioscopy					
35450	C	Repair arterial blockage					
35452	C	Repair arterial blockage					
35454	C	Repair arterial blockage					
35456	C	Repair arterial blockage					
35458	C	Repair arterial blockage					
35459	C	Repair arterial blockage					
35460	C	Repair venous blockage					
35470	C	Repair arterial blockage					
35471	C	Repair arterial blockage					
35472	C	Repair arterial blockage					
35473	C	Repair arterial blockage					
35474	C	Repair arterial blockage					
35475	C	Repair arterial blockage					
35476	C	Repair venous blockage					
35480	C	Atherectomy, open					
35481	C	Atherectomy, open					
35482	C	Atherectomy, open					
35483	C	Atherectomy, open					
35484	C	Atherectomy, open					
35485	C	Atherectomy, open					
35490	C	Atherectomy, percutaneous					
35491	C	Atherectomy, percutaneous					
35492	C	Atherectomy, percutaneous					
35493	C	Atherectomy, percutaneous					
35494	C	Atherectomy, percutaneous					
35495	C	Atherectomy, percutaneous					
35501	C	Artery bypass graft					
35506	C	Artery bypass graft					
35507	C	Artery bypass graft					
35508	C	Artery bypass graft					
35509	C	Artery bypass graft					
35511	C	Artery bypass graft					
35515	C	Artery bypass graft					
35516	C	Artery bypass graft					
35518	C	Artery bypass graft					
35521	C	Artery bypass graft					
35526	C	Artery bypass graft					
35531	C	Artery bypass graft					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
35533	C	Artery bypass graft					
35536	C	Artery bypass graft					
35541	C	Artery bypass graft					
35546	C	Artery bypass graft					
35548	C	Artery bypass graft					
35549	C	Artery bypass graft					
35551	C	Artery bypass graft					
35556	C	Artery bypass graft					
35558	C	Artery bypass graft					
35560	C	Artery bypass graft					
35563	C	Artery bypass graft					
35565	C	Artery bypass graft					
35566	C	Artery bypass graft					
35571	C	Artery bypass graft					
35582	C	Vein bypass graft					
35583	C	Vein bypass graft					
35585	C	Vein bypass graft					
35587	C	Vein bypass graft					
35601	C	Artery bypass graft					
35606	C	Artery bypass graft					
35612	C	Artery bypass graft					
35616	C	Artery bypass graft					
35621	C	Artery bypass graft					
35623	C	Bypass graft, not vein					
35626	C	Artery bypass graft					
35631	C	Artery bypass graft					
35636	C	Artery bypass graft					
35641	C	Artery bypass graft					
35642	C	Artery bypass graft					
35645	C	Artery bypass graft					
35646	C	Artery bypass graft					
35650	C	Artery bypass graft					
35651	C	Artery bypass graft					
35654	C	Artery bypass graft					
35656	C	Artery bypass graft					
35661	C	Artery bypass graft					
35663	C	Artery bypass graft					
35665	C	Artery bypass graft					
35666	C	Artery bypass graft					
35671	C	Artery bypass graft					
35681	C	Artery bypass graft					
35691	C	Arterial transposition					
35693	C	Arterial transposition					
35694	C	Arterial transposition					
35695	C	Arterial transposition					
35700	C	Reoperation, bypass graft					
35701	C	Exploration, carotid artery					
35721	C	Exploration, femoral artery					
35741	C	Exploration popliteal artery					
35761	C	Exploration of artery/vein					
35800	C	Explore neck vessels					
35820	C	Explore chest vessels					
35840	C	Explore abdominal vessels					
35860	C	Explore limb vessels					
35870	C	Repair vessel graft defect					
35875	T	Removal of clot in graft	368	22.83	$1,207.67	$648.85	$241.53
35876	T	Removal of clot in graft	368	22.83	$1,207.67	$648.85	$241.53
35901	C	Excision, graft, neck					
35903	C	Excision, graft, extremity					
35905	C	Excision, graft, thorax					
35907	C	Excision, graft, abdomen					
36000	N	Place needle in vein					
36005	T	Injection, venography	347	2.93	$154.75	$62.15	$30.95
36010	T	Place catheter in vein	342	3.20	$169.45	$80.23	$33.89
36011	T	Place catheter in vein	342	3.20	$169.45	$80.23	$33.89
36012	T	Place catheter in vein	342	3.20	$169.45	$80.23	$33.89
36013	T	Place catheter in artery	342	3.20	$169.45	$80.23	$33.89
36014	T	Place catheter in artery	342	3.20	$169.45	$80.23	$33.89
36015	T	Place catheter in artery	342	3.20	$169.45	$80.23	$33.89
36100	T	Establish access to artery	342	3.20	$169.45	$80.23	$33.89
36120	T	Establish access to artery	342	3.20	$169.45	$80.23	$33.89
36140	T	Establish access to artery	342	3.20	$169.45	$80.23	$33.89
36145	N	Artery to vein shunt					
36160	T	Establish access to aorta	342	3.20	$169.45	$80.23	$33.89
36200	T	Place catheter in aorta	342	3.20	$169.45	$80.23	$33.89

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
36215	T	Place catheter in artery	343	9.52	$503.44	$224.87	$100.69
36216	T	Place catheter in artery	343	9.52	$503.44	$224.87	$100.69
36217	T	Place catheter in artery	343	9.52	$503.44	$224.87	$100.69
36218	T	Place catheter in artery	343	9.52	$503.44	$224.87	$100.69
36245	T	Place catheter in artery	343	9.52	$503.44	$224.87	$100.69
36246	T	Place catheter in artery	343	9.52	$503.44	$224.87	$100.69
36247	T	Place catheter in artery	343	9.52	$503.44	$224.87	$100.69
36248	T	Place catheter in artery	343	9.52	$503.44	$224.87	$100.69
36260	T	Insertion of infusion pump	368	22.83	$1,207.67	$648.85	$241.53
36261	T	Revision of infusion pump	360	6.09	$322.24	$140.12	$64.45
36262	T	Removal of infusion pump	360	6.09	$322.24	$140.12	$64.45
36299	T	Vessel injection procedure	360	6.09	$322.24	$140.12	$64.45
36400	N	Drawing blood					
36405	N	Drawing blood					
36406	N	Drawing blood					
36410	T	Drawing blood	341	0.13	$6.86	$2.94	$1.37
36415	E	Drawing blood					
36420	T	Establish access to vein	341	0.13	$6.86	$2.94	$1.37
36425	T	Establish access to vein	341	0.13	$6.86	$2.94	$1.37
36430	T	Blood transfusion service	369	4.33	$229.19	$97.18	$45.84
36440	T	Blood transfusion service	369	4.33	$229.19	$97.18	$45.84
36450	T	Exchange transfusion service	369	4.33	$229.19	$97.18	$45.84
36455	T	Exchange transfusion service	369	4.33	$229.19	$97.18	$45.84
36460	T	Transfusion service, fetal	369	4.33	$229.19	$97.18	$45.84
36468	T	Injection(s); spider veins	339	1.02	$53.87	$19.66	$10.77
36469	T	Injection(s); spider veins	339	1.02	$53.87	$19.66	$10.77
36470	T	Injection therapy of vein	339	1.02	$53.87	$19.66	$10.77
36471	T	Injection therapy of veins	339	1.02	$53.87	$19.66	$10.77
36481	T	Insertion of catheter, vein	343	9.52	$503.44	$224.87	$100.69
36488	S	Insertion of catheter, vein	346	4.83	$255.64	$120.23	$51.13
36489	S	Insertion of catheter, vein	346	4.83	$255.64	$120.23	$51.13
36490	S	Insertion of catheter, vein	346	4.83	$255.64	$120.23	$51.13
36491	S	Insertion of catheter, vein	346	4.83	$255.64	$120.23	$51.13
36493	S	Repositioning of cvc	346	4.83	$255.64	$120.23	$51.13
36500	T	Insertion of catheter, vein	342	3.20	$169.45	$80.23	$33.89
36510	C	Insertion of catheter, vein					
36520	T	Plasma and/or cell exchange	369	4.33	$229.19	$97.18	$45.84
36522	T	Photopheresis	369	4.33	$229.19	$97.18	$45.84
36530	T	Insertion of infusion pump	368	22.83	$1,207.67	$648.85	$241.53
36531	T	Revision of infusion pump	360	6.09	$322.24	$140.12	$64.45
36532	T	Removal of infusion pump	360	6.09	$322.24	$140.12	$64.45
36533	T	Insertion of access port	368	22.83	$1,207.67	$648.85	$241.53
36534	T	Revision of access port	360	6.09	$322.24	$140.12	$64.45
36535	T	Removal of access port	360	6.09	$322.24	$140.12	$64.45
36600	N	Withdrawal of arterial blood					
36620	T	Insertion catheter, artery	342	3.20	$169.45	$80.23	$33.89
36625	T	Insertion catheter, artery	342	3.20	$169.45	$80.23	$33.89
36640	S	Insertion catheter, artery	346	4.83	$255.64	$120.23	$51.13
36660	C	Insertion catheter, artery					
36680	X	Insert needle, bone cavity	906	1.46	$77.38	$42.49	$15.48
36800	T	Insertion of cannula	368	22.83	$1,207.67	$648.85	$241.53
36810	T	Insertion of cannula	368	22.83	$1,207.67	$648.85	$241.53
36815	T	Insertion of cannula	368	22.83	$1,207.67	$648.85	$241.53
36821	T	Artery-vein fusion	368	22.83	$1,207.67	$648.85	$241.53
36822	C	Insertion of cannula(s)					
36825	T	Artery-vein graft	368	22.83	$1,207.67	$648.85	$241.53
36830	T	Artery-vein graft	368	22.83	$1,207.67	$648.85	$241.53
36832	T	Revise artery-vein fistula	368	22.83	$1,207.67	$648.85	$241.53
36834	C	Repair A–V aneurysm					
36835	T	Artery to vein shunt	368	22.83	$1,207.67	$648.85	$241.53
36860	T	Cannula declotting	368	22.83	$1,207.67	$648.85	$241.53
36861	T	Cannula declotting	368	22.83	$1,207.67	$648.85	$241.53
37140	C	Revision of circulation					
37145	C	Revision of circulation					
37160	C	Revision of circulation					
37180	C	Revision of circulation					
37181	C	Splice spleen/kidney veins					
37195	C	Thrombolytic therapy, stroke					
37200	C	Transcatheter biopsy					
37201	C	Transcatheter therapy infuse					
37202	C	Transcatheter therapy infuse					
37203	T	Transcatheter retrieval	360	6.09	$322.24	$140.12	$64.45
37204	C	Transcatheter occlusion					
37205	C	Transcatheter stent					
37206	C	Transcatheter stent					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
37207	C	Transcatheter stent					
37208	C	Transcatheter stent					
37209	C	Exchange arterial catheter					
37250	C	Intravascular us					
37251	C	Intravascular us					
37565	C	Ligation of neck vein					
37600	C	Ligation of neck artery					
37605	C	Ligation of neck artery					
37606	C	Ligation of neck artery					
37607	T	Ligation of fistula	368	22.83	$1,207.67	$648.85	$241.53
37609	T	Temporal artery procedure	162	5.67	$299.71	$125.43	$59.94
37615	C	Ligation of neck artery					
37616	C	Ligation of chest artery					
37617	C	Ligation of abdomen artery					
37618	T	Ligation of extremity artery	367	17.59	$930.48	$449.06	$186.10
37620	C	Revision of major vein					
37650	T	Revision of major vein	367	17.59	$930.48	$449.06	$186.10
37660	C	Revision of major vein					
37700	T	Revise leg vein	367	17.59	$930.48	$449.06	$186.10
37720	T	Removal of leg vein	367	17.59	$930.48	$449.06	$186.10
37730	T	Removal of leg veins	367	17.59	$930.48	$449.06	$186.10
37735	T	Removal of leg veins/lesion	367	17.59	$930.48	$449.06	$186.10
37760	T	Revision of leg veins	367	17.59	$930.48	$449.06	$186.10
37780	T	Revision of leg vein	367	17.59	$930.48	$449.06	$186.10
37785	T	Revise secondary varicosity	367	17.59	$930.48	$449.06	$186.10
37788	C	Revascularization, penis					
37790	T	Penile venous occlusion	537	28.72	$1,519.13	$864.45	$303.83
37799	T	Vascular surgery procedure	162	5.67	$299.71	$125.43	$59.94
38100	C	Removal of spleen, total					
38101	C	Removal of spleen, partial					
38102	C	Removal of spleen, total					
38115	C	Repair of ruptured spleen					
38200	T	Injection for spleen x-ray	347	2.93	$154.75	$62.15	$30.95
38230	T	Bone marrow collection	369	4.33	$229.19	$97.18	$45.84
38231	T	Stem cell collection	369	4.33	$229.19	$97.18	$45.84
38240	C	Bone marrow/stem transplant					
38241	C	Bone marrow/stem transplant					
38300	T	Drainage lymph node lesion	132	6.04	$319.3	$134.24	$63.86
38305	T	Drainage lymph node lesion	132	6.04	$319.3	$134.24	$63.86
38308	T	Incision of lymph channels	396	13.28	$702.27	$338.77	$140.45
38380	C	Thoracic duct procedure					
38381	C	Thoracic duct procedure					
38382	C	Thoracic duct procedure					
38500	T	Biopsy/removal, lymph node(s)	396	13.28	$702.27	$338.77	$140.45
38505	T	Needle biopsy, lymph node(s)	122	4.87	$257.6	$115.03	$51.52
38510	T	Biopsy/removal, lymph node(s)	396	13.28	$702.27	$338.77	$140.45
38520	T	Biopsy/removal, lymph node(s)	396	13.28	$702.27	$338.77	$140.45
38525	T	Biopsy/removal, lymph node(s)	396	13.28	$702.27	$338.77	$140.45
38530	T	Biopsy/removal, lymph node(s)	396	13.28	$702.27	$338.77	$140.45
38542	T	Explore deep node(s), neck	397	18.37	$971.62	$496.97	$194.32
38550	T	Removal neck/armpit lesion	396	13.28	$702.27	$338.77	$140.45
38555	T	Removal neck/armpit lesion	397	18.37	$971.62	$496.97	$194.32
38562	C	Removal, pelvic lymph nodes					
38564	C	Removal, abdomen lymph nodes					
38700	C	Removal of lymph nodes, neck					
38720	C	Removal of lymph nodes, neck					
38724	C	Removal of lymph nodes, neck					
38740	T	Remove armpit lymph nodes	397	18.37	$971.62	$496.97	$194.32
38745	T	Remove armpits lymph nodes	397	18.37	$971.62	$496.97	$194.32
38746	C	Remove thoracic lymph nodes					
38747	C	Remove abdominal lymph nodes					
38760	T	Remove groin lymph nodes	397	18.37	$971.62	$496.97	$194.32
38765	C	Remove groin lymph nodes					
38770	C	Remove pelvis lymph nodes					
38780	C	Remove abdomen lymph nodes					
38790	T	Injection for lymphatic xray	347	2.93	$154.75	$62.15	$30.95
38794	T	Access thoracic lymph duct	342	3.20	$169.45	$80.23	$33.89
38999	T	Blood/lymph system procedure	132	6.04	$319.30	$134.24	$63.86
39000	C	Exploration of chest					
39010	C	Exploration of chest					
39200	C	Removal chest lesion					
39220	C	Removal chest lesion					
39400	C	Visualization of chest					
39499	C	Chest procedure					
39501	C	Repair diaphragm laceration					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
39502	C	Repair paraesophageal hernia	.....	.....	.....	.....	.....
39503	C	Repair of diaphragm hernia	.....	.....	.....	.....	.....
39520	C	Repair of diaphragm hernia	.....	.....	.....	.....	.....
39530	C	Repair of diaphragm hernia	.....	.....	.....	.....	.....
39531	C	Repair of diaphragm hernia	.....	.....	.....	.....	.....
39540	C	Repair of diaphragm hernia	.....	.....	.....	.....	.....
39541	C	Repair of diaphragm hernia	.....	.....	.....	.....	.....
39545	C	Revision of diaphragm	.....	.....	.....	.....	.....
39599	C	Diaphragm surgery procedure	.....	.....	.....	.....	.....
40490	T	Biopsy of lip	311	1.43	$75.42	$20.57	$15.08
40500	T	Partial excision of lip	313	15.81	$836.45	$411.09	$167.29
40510	T	Partial excision of lip	313	15.81	$836.45	$411.09	$167.29
40520	T	Partial excision of lip	313	15.81	$836.45	$411.09	$167.29
40525	T	Reconstruct lip with flap	313	15.81	$836.45	$411.09	$167.29
40527	T	Reconstruct lip with flap	313	15.81	$836.45	$411.09	$167.29
40530	T	Partial removal of lip	313	15.81	$836.45	$411.09	$167.29
40650	T	Repair lip	313	15.81	$836.45	$411.09	$167.29
40652	T	Repair lip	313	15.81	$836.45	$411.09	$167.29
40654	T	Repair lip	313	15.81	$836.45	$411.09	$167.29
40700	T	Repair cleft lip/nasal	314	25.65	$1,356.54	$693.37	$271.31
40701	T	Repair cleft lip/nasal	314	25.65	$1,356.54	$693.37	$271.31
40702	T	Repair cleft lip/nasal	314	25.65	$1,356.54	$693.37	$271.31
40720	T	Repair cleft lip/nasal	314	25.65	$1,356.54	$693.37	$271.31
40761	T	Repair cleft lip/nasal	314	25.65	$1,356.54	$693.37	$271.31
40799	T	Lip surgery procedure	311	1.43	$75.42	$20.57	$15.08
40800	T	Drainage of mouth lesion	311	1.43	$75.42	$20.57	$15.08
40801	T	Drainage of mouth lesion	311	1.43	$75.42	$20.57	$15.08
40804	T	Removal foreign body, mouth	311	1.43	$75.42	$20.57	$15.08
40805	T	Removal foreign body, mouth	311	1.43	$75.42	$20.57	$15.08
40806	T	Incision of lip fold	311	1.43	$75.42	$20.57	$15.08
40808	T	Biopsy of mouth lesion	311	1.43	$75.42	$20.57	$15.08
40810	T	Excision of mouth lesion	311	1.43	$75.42	$20.57	$15.08
40812	T	Excise/repair mouth lesion	311	1.43	$75.42	$20.57	$15.08
40814	T	Excise/repair mouth lesion	313	15.81	$836.45	$411.09	$167.29
40816	T	Excision of mouth lesion	313	15.81	$836.45	$411.09	$167.29
40818	T	Excise oral mucosa for graft	313	15.81	$836.45	$411.09	$167.29
40819	T	Excise lip or cheek fold	313	15.81	$836.45	$411.09	$167.29
40820	T	Treatment of mouth lesion	311	1.43	$75.42	$20.57	$15.08
40830	T	Repair mouth laceration	312	7.26	$383.95	$178.31	$76.79
40831	T	Repair mouth laceration	312	7.26	$383.95	$178.31	$76.79
40840	T	Reconstruction of mouth	313	15.81	$836.45	$411.09	$167.29
40842	T	Reconstruction of mouth	313	15.81	$836.45	$411.09	$167.29
40843	T	Reconstruction of mouth	314	25.65	$1,356.54	$693.37	$271.31
40844	T	Reconstruction of mouth	314	25.65	$1,356.54	$693.37	$271.31
40845	T	Reconstruction of mouth	314	25.65	$1,356.54	$693.37	$271.31
40899	T	Mouth surgery procedure	311	1.43	$75.42	$20.57	$15.08
41000	T	Drainage of mouth lesion	311	1.43	$75.42	$20.57	$15.08
41005	T	Drainage of mouth lesion	311	1.43	$75.42	$20.57	$15.08
41006	T	Drainage of mouth lesion	313	15.81	$836.45	$411.09	$167.29
41007	T	Drainage of mouth lesion	313	15.81	$836.45	$411.09	$167.29
41008	T	Drainage of mouth lesion	313	15.81	$836.45	$411.09	$167.29
41009	T	Drainage of mouth lesion	313	15.81	$836.45	$411.09	$167.29
41010	T	Incision of tongue fold	313	15.81	$836.45	$411.09	$167.29
41015	T	Drainage of mouth lesion	313	15.81	$836.45	$411.09	$167.29
41016	T	Drainage of mouth lesion	313	15.81	$836.45	$411.09	$167.29
41017	T	Drainage of mouth lesion	313	15.81	$836.45	$411.09	$167.29
41018	T	Drainage of mouth lesion	313	15.81	$836.45	$411.09	$167.29
41100	T	Biopsy of tongue	311	1.43	$75.42	$20.57	$15.08
41105	T	Biopsy of tongue	311	1.43	$75.42	$20.57	$15.08
41108	T	Biopsy of floor of mouth	311	1.43	$75.42	$20.57	$15.08
41110	T	Excision of tongue lesion	311	1.43	$75.42	$20.57	$15.08
41112	T	Excision of tongue lesion	313	15.81	$836.45	$411.09	$167.29
41113	T	Excision of tongue lesion	313	15.81	$836.45	$411.09	$167.29
41114	T	Excision of tongue lesion	313	15.81	$836.45	$411.09	$167.29
41115	T	Excision of tongue fold	311	1.43	$75.42	$20.57	$15.08
41116	T	Excision of mouth lesion	313	15.81	$836.45	$411.09	$167.29
41120	T	Partial removal of tongue	313	15.81	$836.45	$411.09	$167.29
41130	C	Partial removal of tongue	.....	.....	.....	.....	.....
41135	C	Tongue and neck surgery	.....	.....	.....	.....	.....
41140	C	Removal of tongue	.....	.....	.....	.....	.....
41145	C	Tongue removal; neck surgery	.....	.....	.....	.....	.....
41150	C	Tongue, mouth, jaw surgery	.....	.....	.....	.....	.....
41153	C	Tongue, mouth, neck surgery	.....	.....	.....	.....	.....
41155	C	Tongue, jaw, & neck surgery	.....	.....	.....	.....	.....
41250	T	Repair tongue laceration	312	7.26	$383.95	$178.31	$76.79

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
41251	T	Repair tongue laceration	312	7.26	$383.95	$178.31	$76.79
41252	T	Repair tongue laceration	312	7.26	$383.95	$178.31	$76.79
41500	T	Fixation of tongue	312	7.26	$383.95	$178.31	$76.79
41510	T	Tongue to lip surgery	312	7.26	$383.95	$178.31	$76.79
41520	T	Reconstruction, tongue fold	313	15.81	$836.45	$411.09	$167.29
41599	T	Tongue and mouth surgery	311	1.43	$75.42	$20.57	$15.08
41800	T	Drainage of gum lesion	312	7.26	$383.95	$178.31	$76.79
41805	T	Removal foreign body, gum	311	1.43	$75.42	$20.57	$15.08
41806	T	Removal foreign body, jawbone	311	1.43	$75.42	$20.57	$15.08
41820	T	Excision, gum, each quadrant	311	1.43	$75.42	$20.57	$15.08
41821	T	Excision of gum flap	311	1.43	$75.42	$20.57	$15.08
41822	T	Excision of gum lesion	231	12.02	$635.66	$299.9	$127.13
41823	T	Excision of gum lesion	231	12.02	$635.66	$299.9	$127.13
41825	T	Excision of gum lesion	311	1.43	$75.42	$20.57	$15.08
41826	T	Excision of gum lesion	311	1.43	$75.42	$20.57	$15.08
41827	T	Excision of gum lesion	313	15.81	$836.45	$411.09	$167.29
41828	T	Excision of gum lesion	311	1.43	$75.42	$20.57	$15.08
41830	T	Removal of gum tissue	311	1.43	$75.42	$20.57	$15.08
41850	T	Treatment of gum lesion	311	1.43	$75.42	$20.57	$15.08
41870	T	Gum graft	311	1.43	$75.42	$20.57	$15.08
41872	T	Repair gum	311	1.43	$75.42	$20.57	$15.08
41874	T	Repair tooth socket	311	1.43	$75.42	$20.57	$15.08
41899	T	Dental surgery procedure	311	1.43	$75.42	$20.57	$15.08
42000	T	Drainage mouth roof lesion	311	1.43	$75.42	$20.57	$15.08
42100	T	Biopsy roof of mouth	311	1.43	$75.42	$20.57	$15.08
42104	T	Excision lesion, mouth roof	311	1.43	$75.42	$20.57	$15.08
42106	T	Excision lesion, mouth roof	311	1.43	$75.42	$20.57	$15.08
42107	T	Excision lesion, mouth roof	313	15.81	$836.45	$411.09	$167.29
42120	T	Remove palate/lesion	313	15.81	$836.45	$411.09	$167.29
42140	T	Excision of uvula	311	1.43	$75.42	$20.57	$15.08
42145	C	Repair, palate,pharynx/uvula	.....	.....	.....	.....	.....
42160	T	Treatment mouth roof lesion	311	1.43	$75.42	$20.57	$15.08
42180	T	Repair palate	313	15.81	$836.45	$411.09	$167.29
42182	T	Repair palate	313	15.81	$836.45	$411.09	$167.29
42200	T	Reconstruct cleft palate	313	15.81	$836.45	$411.09	$167.29
42205	T	Reconstruct cleft palate	313	15.81	$836.45	$411.09	$167.29
42210	T	Reconstruct cleft palate	314	25.65	$1,356.54	$693.37	$271.31
42215	T	Reconstruct cleft palate	313	15.81	$836.45	$411.09	$167.29
42220	T	Reconstruct cleft palate	313	15.81	$836.45	$411.09	$167.29
42225	T	Reconstruct cleft palate	314	25.65	$1,356.54	$693.37	$271.31
42226	T	Lengthening of palate	314	25.65	$1,356.54	$693.37	$271.31
42227	T	Lengthening of palate	314	25.65	$1,356.54	$693.37	$271.31
42235	T	Repair palate	313	15.81	$836.45	$411.09	$167.29
42260	T	Repair nose to lip fistula	313	15.81	$836.45	$411.09	$167.29
42280	T	Preparation, palate mold	311	1.43	$75.42	$20.57	$15.08
42281	T	Insertion, palate prosthesis	311	1.43	$75.42	$20.57	$15.08
42299	T	Palate/uvula surgery	311	1.43	$75.42	$20.57	$15.08
42300	T	Drainage of salivary gland	312	7.26	$383.95	$178.31	$76.79
42305	T	Drainage of salivary gland	312	7.26	$383.95	$178.31	$76.79
42310	T	Drainage of salivary gland	312	7.26	$383.95	$178.31	$76.79
42320	T	Drainage of salivary gland	312	7.26	$383.95	$178.31	$76.79
42325	T	Create salivary cyst drain	313	15.81	$836.45	$411.09	$167.29
42326	T	Create salivary cyst drain	313	15.81	$836.45	$411.09	$167.29
42330	T	Removal of salivary stone	311	1.43	$75.42	$20.57	$15.08
42335	T	Removal of salivary stone	311	1.43	$75.42	$20.57	$15.08
42340	T	Removal of salivary stone	313	15.81	$836.45	$411.09	$167.29
42400	T	Biopsy of salivary gland	122	4.87	$257.6	$115.03	$51.52
42405	T	Biopsy of salivary gland	312	7.26	$383.95	$178.31	$76.79
42408	T	Excision of salivary cyst	313	15.81	$836.45	$411.09	$167.29
42409	T	Drainage of salivary cyst	313	15.81	$836.45	$411.09	$167.29
42410	T	Excise parotid gland/lesion	313	15.81	$836.45	$411.09	$167.29
42415	T	Excise parotid gland/lesion	314	25.65	$1,356.54	$693.37	$271.31
42420	T	Excise parotid gland/lesion	314	25.65	$1,356.54	$693.37	$271.31
42425	T	Excise parotid gland/lesion	314	25.65	$1,356.54	$693.37	$271.31
42426	C	Excise parotid gland/lesion	.....	.....	.....	.....	.....
42440	T	Excision submaxillary gland	313	15.81	$836.45	$411.09	$167.29
42450	T	Excision sublingual gland	313	15.81	$836.45	$411.09	$167.29
42500	T	Repair salivary duct	313	15.81	$836.45	$411.09	$167.29
42505	T	Repair salivary duct	313	15.81	$836.45	$411.09	$167.29
42507	T	Parotid duct diversion	313	15.81	$836.45	$411.09	$167.29
42508	T	Parotid duct diversion	313	15.81	$836.45	$411.09	$167.29
42509	T	Parotid duct diversion	314	25.65	$1,356.54	$693.37	$271.31
42510	T	Parotid duct diversion	313	15.81	$836.45	$411.09	$167.29
42550	T	Injection for salivary x-ray	347	2.93	$154.75	$62.15	$30.95
42600	T	Closure of salivary fistula	313	15.81	$836.45	$411.09	$167.29

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
42650	T	Dilation of salivary duct	311	1.43	$75.42	$20.57	$15.08
42660	T	Dilation of salivary duct	311	1.43	$75.42	$20.57	$15.08
42665	T	Ligation of salivary duct	311	1.43	$75.42	$20.57	$15.08
42699	T	Salivary surgery procedure	311	1.43	$75.42	$20.57	$15.08
42700	T	Drainage of tonsil abscess	312	7.26	$383.95	$178.31	$76.79
42720	T	Drainage of throat abscess	312	7.26	$383.95	$178.31	$76.79
42725	T	Drainage of throat abscess	313	15.81	$836.45	$411.09	$167.29
42800	T	Biopsy of throat	312	7.26	$383.95	$178.31	$76.79
42802	T	Biopsy of throat	312	7.26	$383.95	$178.31	$76.79
42804	T	Biopsy of upper nose/throat	312	7.26	$383.95	$178.31	$76.79
42806	T	Biopsy of upper nose/throat	312	7.26	$383.95	$178.31	$76.79
42808	T	Excise pharynx lesion	312	7.26	$383.95	$178.31	$76.79
42809	T	Remove pharynx foreign body	151	1.74	$92.07	$35.71	$18.41
42810	T	Excision of neck cyst	313	15.81	$836.45	$411.09	$167.29
42815	T	Excision of neck cyst	313	15.81	$836.45	$411.09	$167.29
42820	T	Remove tonsils and adenoids	319	17.30	$914.81	$480.02	$182.96
42821	T	Remove tonsils and adenoids	319	17.30	$914.81	$480.02	$182.96
42825	T	Removal of tonsils	319	17.30	$914.81	$480.02	$182.96
42826	T	Removal of tonsils	319	17.30	$914.81	$480.02	$182.96
42830	T	Removal of adenoids	319	17.30	$914.81	$480.02	$182.96
42831	T	Removal of adenoids	319	17.30	$914.81	$480.02	$182.96
42835	T	Removal of adenoids	319	17.30	$914.81	$480.02	$182.96
42836	T	Removal of adenoids	319	17.30	$914.81	$480.02	$182.96
42842	T	Extensive surgery of throat	314	25.65	$1,356.54	$693.37	$271.31
42844	T	Extensive surgery of throat	314	25.65	$1,356.54	$693.37	$271.31
42845	C	Extensive surgery of throat	.....	.....	.....	.....	.....
42860	T	Excision of tonsil tags	319	17.30	$914.81	$480.02	$182.96
42870	T	Excision of lingual tonsil	319	17.30	$914.81	$480.02	$182.96
42890	T	Partial removal of pharynx	314	25.65	$1,356.54	$693.37	$271.31
42892	T	Revision of pharyngeal walls	314	25.65	$1,356.54	$693.37	$271.31
42894	C	Revision of pharyngeal walls	.....	.....	.....	.....	.....
42900	T	Repair throat wound	313	15.81	$836.45	$411.09	$167.29
42950	T	Reconstruction of throat	313	15.81	$836.45	$411.09	$167.29
42953	C	Repair throat, esophagus	.....	.....	.....	.....	.....
42955	T	Surgical opening of throat	313	15.81	$836.45	$411.09	$167.29
42960	T	Control throat bleeding	318	2.07	$109.7	$38.65	$21.94
42961	C	Control throat bleeding	.....	.....	.....	.....	.....
42962	T	Control throat bleeding	313	15.81	$836.45	$411.09	$167.29
42970	T	Control nose/throat bleeding	318	2.07	$109.7	$38.65	$21.94
42971	C	Control nose/throat bleeding	.....	.....	.....	.....	.....
42972	T	Control nose/throat bleeding	313	15.81	$836.45	$411.09	$167.29
42999	T	Throat surgery procedure	318	2.07	$109.7	$38.65	$21.94
43020	T	Incision of esophagus	313	15.81	$836.45	$411.09	$167.29
43030	T	Throat muscle surgery	313	15.81	$836.45	$411.09	$167.29
43045	C	Incision of esophagus	.....	.....	.....	.....	.....
43100	C	Excision of esophagus lesion	.....	.....	.....	.....	.....
43101	C	Excision of esophagus lesion	.....	.....	.....	.....	.....
43107	C	Removal of esophagus	.....	.....	.....	.....	.....
43108	C	Removal of esophagus	.....	.....	.....	.....	.....
43112	C	Removal of esophagus	.....	.....	.....	.....	.....
43113	C	Removal of esophagus	.....	.....	.....	.....	.....
43116	C	Partial removal of esophagus	.....	.....	.....	.....	.....
43117	C	Partial removal of esophagus	.....	.....	.....	.....	.....
43118	C	Partial removal of esophagus	.....	.....	.....	.....	.....
43121	C	Partial removal of esophagus	.....	.....	.....	.....	.....
43122	C	Parital removal of esophagus	.....	.....	.....	.....	.....
43123	C	Partial removal of esophagus	.....	.....	.....	.....	.....
43124	C	Removal of esophagus	.....	.....	.....	.....	.....
43130	C	Removal of esophagus pouch	.....	.....	.....	.....	.....
43135	C	Removal of esophagus pouch	.....	.....	.....	.....	.....
43200	T	Esophagus endoscopy	417	6.44	$340.85	$181.70	$68.17
43202	T	Esophagus endoscopy, biopsy	417	6.44	$340.85	$181.70	$68.17
43204	T	Esophagus endoscopy & inject	407	7.06	$373.17	$189.84	$74.63
43205	T	Esophagus endoscopy/ligation	407	7.06	$373.17	$189.84	$74.63
43215	T	Esophagus endoscopy	407	7.06	$373.17	$189.84	$74.63
43216	T	Esophagus endoscopy/lesion	407	7.06	$373.17	$189.84	$74.63
43217	T	Esophagus endoscopy	407	7.06	$373.17	$189.84	$74.63
43219	T	Esophagus endoscopy	449	7.80	$412.35	$215.38	$82.47
43220	T	Esophagus endoscopy,dilation	407	7.06	$373.17	$189.84	$74.63
43226	T	Esophagus endoscopy,dilation	407	7.06	$373.17	$189.84	$74.63
43227	T	Esophagus endoscopy, repair	407	7.06	$373.17	$189.84	$74.63
43228	T	Esophagus endoscopy,ablation	449	7.80	$412.35	$215.38	$82.47
43234	T	Upper GI endoscopy, exam	417	6.44	$340.85	$181.70	$68.17
43235	T	Upper gi endoscopy,diagnosis	417	6.44	$340.85	$181.70	$68.17
43239	T	Upper GI endoscopy, biopsy	417	6.44	$340.85	$181.70	$68.17

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
43241	T	Upper GI endoscopy with tube	418	7.59	$401.58	$214.25	$80.32
43243	T	Upper GI endoscopy & inject.	418	7.59	$401.58	$214.25	$80.32
43244	T	Upper GI endoscopy/ligation	418	7.59	$401.58	$214.25	$80.32
43245	T	Operative upper GI endoscopy	418	7.59	$401.58	$214.25	$80.32
43246	T	Place gastrostomy tube	418	7.59	$401.58	$214.25	$80.32
43247	T	Operative upper GI endoscopy	418	7.59	$401.58	$214.25	$80.32
43248	T	Upper GI endoscopy/guidewire	418	7.59	$401.58	$214.25	$80.32
43249	T	Esophagus endoscopy,dilation	418	7.59	$401.58	$214.25	$80.32
43250	T	Upper GI endoscopy/tumor	418	7.59	$401.58	$214.25	$80.32
43251	T	Operative upper GI endoscopy	418	7.59	$401.58	$214.25	$80.32
43255	T	Operative upper GI endoscopy	418	7.59	$401.58	$214.25	$80.32
43258	T	Operative upper GI endoscopy	449	7.80	$412.35	$215.38	$82.47
43259	T	Endoscopic ultrasound exam	449	7.80	$412.35	$215.38	$82.47
43260	T	Endoscopy,bile duct/pancreas	456	9.78	$517.15	$257.19	$103.43
43261	T	Endoscopy,bile duct/pancreas	456	9.78	$517.15	$257.19	$103.43
43262	T	Endoscopy,bile duct/pancreas	456	9.78	$517.15	$257.19	$103.43
43263	T	Endoscopy,bile duct/pancreas	456	9.78	$517.15	$257.19	$103.43
43264	T	Endoscopy,bile duct/pancreas	456	9.78	$517.15	$257.19	$103.43
43265	T	Endoscopy,bile duct/pancreas	456	9.78	$517.15	$257.19	$103.43
43267	T	Endoscopy,bile duct/pancreas	456	9.78	$517.15	$257.19	$103.43
43268	T	Endoscopy,bile duct/pancreas	456	9.78	$517.15	$257.19	$103.43
43269	T	Endoscopy,bile duct/pancreas	456	9.78	$517.15	$257.19	$103.43
43271	T	Endoscopy,bile duct/pancreas	456	9.78	$517.15	$257.19	$103.43
43272	T	Endoscopy,bile duct/pancreas	449	7.80	$412.35	$215.38	$82.47
43300	C	Repair of esophagus					
43305	C	Repair esophagus and fistula					
43310	C	Repair of esophagus					
43312	C	Repair esophagus and fistula					
43320	C	Fuse esophagus & stomach					
43324	C	Revise esophagus & stomach					
43325	C	Revise esophagus & stomach					
43326	C	Revise esophagus & stomach					
43330	C	Repair of esophagus					
43331	C	Repair of esophagus					
43340	C	Fuse esophagus & intestine					
43341	C	Fuse esophagus & intestine					
43350	C	Surgical opening, esophagus					
43351	C	Surgical opening, esophagus					
43352	C	Surgical opening, esophagus					
43360	C	Gastrointestinal repair					
43361	C	Gastrointestinal repair					
43400	C	Ligate esophagus veins					
43401	C	Esophagus surgery for veins					
43405	C	Ligate/staple esophagus					
43410	C	Repair esophagus wound					
43415	C	Repair esophagus wound					
43420	C	Repair esophagus opening					
43425	C	Repair esophagus opening					
43450	T	Dilate esophagus	406	4.31	$228.21	$108.48	$45.64
43453	T	Dilate esophagus	406	4.31	$228.21	$108.48	$45.64
43456	T	Dilate esophagus	406	4.31	$228.21	$108.48	$45.64
43458	T	Dilation of esophagus	406	4.31	$228.21	$108.48	$45.64
43460	C	Pressure treatment esophagus					
43496	C	Free jejunum flap, microvasc					
43499	T	Esophagus surgery procedure	406	4.31	$228.21	$108.48	$45.64
43500	C	Surgical opening of stomach					
43501	C	Surgical repair of stomach					
43502	C	Surgical repair of stomach					
43510	C	Surgical opening of stomach					
43520	C	Incision of pyloric muscle					
43600	T	Biopsy of stomach	417	6.44	$340.85	$181.70	$68.17
43605	C	Biopsy of stomach					
43610	C	Excision of stomach lesion					
43611	C	Excision of stomach lesion					
43620	C	Removal of stomach					
43621	C	Removal of stomach					
43622	C	Removal of stomach					
43631	C	Removal of stomach, partial					
43632	C	Removal stomach, partial					
43633	C	Removal stomach, partial					
43634	C	Removal stomach, partial					
43635	C	Partial removal of stomach					
43638	C	Partial removal of stomach					
43639	C	Removal stomach, partial					
43640	C	Vagotomy & pylorus repair					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
43641	C	Vagotomy & pylorus repair					
43750	T	Place gastrostomy tube	418	7.59	$401.58	$214.25	$80.32
43760	T	Change gastrostomy tube	470	2.22	$117.53	$54.92	$23.51
43761	T	Reposition gastrostomy tube	470	2.22	$117.53	$54.92	$23.51
43800	C	Reconstruction of pylorus					
43810	C	Fusion of stomach and bowel					
43820	C	Fusion of stomach and bowel					
43825	C	Fusion of stomach and bowel					
43830	C	Place gastrostomy tube					
43831	C	Place gastrostomy tube					
43832	C	Place gastrostomy tube					
43840	C	Repair of stomach lesion					
43842	C	Gastroplasty for obesity					
43843	C	Gastroplasty for obesity					
43846	C	Gastric bypass for obesity					
43847	C	Gastric bypass for obesity					
43848	C	Revision gastroplasty					
43850	C	Revise stomach-bowel fusion					
43855	C	Revise stomach-bowel fusion					
43860	C	Revise stomach-bowel fusion					
43865	C	Revise stomach-bowel fusion					
43870	T	Repair stomach opening	182	4.00	$211.56	$84.98	$42.31
43880	C	Repair stomach-bowel fistula					
43999	T	Stomach surgery procedure	470	2.22	$117.53	$54.92	$23.51
44005	C	Freeing of bowel adhesion					
44010	C	Incision of small bowel					
44015	C	Insert needle catheter, bowel					
44020	C	Exploration of small bowel					
44021	C	Decompress small bowel					
44025	C	Incision of large bowel					
44050	C	Reduce bowel obstruction					
44055	C	Correct malrotation of bowel					
44100	T	Biopsy of bowel	417	6.44	$340.85	$181.70	$68.17
44110	C	Excision of bowel lesion(s)					
44111	C	Excision of bowel lesion(s)					
44120	C	Removal of small intestine					
44121	C	Removal of small intestine					
44125	C	Removal of small intestine					
44130	C	Bowel to bowel fusion					
44139	C	Mobilization of colon					
44140	C	Partial removal of colon					
44141	C	Partial removal of colon					
44143	C	Partial removal of colon					
44144	C	Partial removal of colon					
44145	C	Partial removal of colon					
44146	C	Partial removal of colon					
44147	C	Partial removal of colon					
44150	C	Removal of colon					
44151	C	Removal of colon/ileostomy					
44152	C	Removal of colon/ileostomy					
44153	C	Removal of colon/ileostomy					
44155	C	Removal of colon					
44156	C	Removal of colon/ileostomy					
44160	C	Removal of colon					
44300	C	Open bowel to skin					
44310	C	Ileostomy/jejunostomy					
44312	T	Revision of ileostomy	183	11.17	$590.61	$286.57	$118.12
44314	C	Revision of ileostomy					
44316	C	Devise bowel pouch					
44320	C	Colostomy					
44322	C	Colostomy with biopsies					
44340	T	Revision of colostomy	183	11.17	$590.61	$286.57	$118.12
44345	C	Revision of colostomy					
44346	C	Revision of colostomy					
44360	T	Small bowel endoscopy	419	7.13	$377.09	$164.08	$75.42
44361	T	Small bowel endoscopy,biopsy	419	7.13	$377.09	$164.08	$75.42
44363	T	Small bowel endoscopy	419	7.13	$377.09	$164.08	$75.42
44364	T	Small bowel endoscopy	419	7.13	$377.09	$164.08	$75.42
44365	T	Small bowel endoscopy	419	7.13	$377.09	$164.08	$75.42
44366	T	Small bowel endoscopy	419	7.13	$377.09	$164.08	$75.42
44369	T	Small bowel endoscopy	449	7.80	$412.35	$215.38	$82.47
44372	T	Small bowel endoscopy	419	7.13	$377.09	$164.08	$75.42
44373	T	Small bowel endoscopy	419	7.13	$377.09	$164.08	$75.42
44376	T	Small bowel endoscopy	419	7.13	$377.09	$164.08	$75.42
44377	T	Small bowel endoscopy	419	7.13	$377.09	$164.08	$75.42

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
44378	T	Small bowel endoscopy	419	7.13	$377.09	$164.08	$75.42
44380	T	Small bowel endoscopy	426	6.85	$362.40	$187.81	$72.48
44382	T	Small bowel endoscopy	426	6.85	$362.40	$187.81	$72.48
44385	T	Endoscopy of bowel pouch	426	6.85	$362.40	$187.81	$72.48
44386	T	Endoscopy, bowel pouch, biopsy	426	6.85	$362.40	$187.81	$72.48
44388	T	Colon endoscopy	426	6.85	$362.40	$187.81	$72.48
44389	T	Colonoscopy with biopsy	426	6.85	$362.40	$187.81	$72.48
44390	T	Colonoscopy for foreign body	427	8.22	$434.88	$224.19	$86.98
44391	T	Colonoscopy for bleeding	427	8.22	$434.88	$224.19	$86.98
44392	T	Colonoscopy & polypectomy	427	8.22	$434.88	$224.19	$86.98
44393	T	Colonoscopy, lesion removal	449	7.80	$412.35	$215.38	$82.47
44394	T	Colonoscopy w/snare	427	8.22	$434.88	$224.19	$86.98
44500	C	Intro, gastrointestinal tube					
44602	C	Suture, small intestine					
44603	C	Suture, small intestine					
44604	C	Suture, large intestine					
44605	C	Repair of bowel lesion					
44615	C	Intestinal stricturoplasty					
44620	C	Repair bowel opening					
44625	C	Repair bowel opening					
44626	C	Repair bowel opening					
44640	C	Repair bowel-skin fistula					
44650	C	Repair bowel fistula					
44660	C	Repair bowel-bladder fistula					
44661	C	Repair bowel-bladder fistula					
44680	C	Surgical revision, intestine					
44700	C	Suspend bowel w/prosthesis					
44799	T	Intestine surgery procedure	419	7.13	$377.09	$164.08	$75.42
44800	C	Excision of bowel pouch					
44820	C	Excision of mesentery lesion					
44850	C	Repair of mesentery					
44899	C	Bowel surgery procedure					
44900	C	Drain, app abscess, open					
44901	C	Drain, app abscess, perc					
44950	C	Appendectomy					
44955	C	Appendectomy					
44960	C	Appendectomy					
45000	T	Drainage of pelvic abscess	452	4.83	$255.64	$109.61	$51.13
45005	T	Drainage of rectal abscess	452	4.83	$255.64	$109.61	$51.13
45020	T	Drainage of rectal abscess	452	4.83	$255.64	$109.61	$51.13
45100	T	Biopsy of rectum	452	4.83	$255.64	$109.61	$51.13
45108	T	Removal of anorectal lesion	453	16.87	$892.28	$445.22	$178.46
45110	C	Removal of rectum					
45111	C	Partial removal of rectum					
45112	C	Removal of rectum					
45113	C	Partial proctectomy					
45114	C	Partial removal of rectum					
45116	C	Partial removal of rectum					
45119	C	Remove, rectum w/reservoir					
45120	C	Removal of rectum					
45121	C	Removal of rectum and colon					
45123	C	Partial proctectomy					
45130	C	Excision of rectal prolapse					
45135	C	Excision of rectal prolapse					
45150	T	Excision of rectal stricture	453	16.87	$892.28	$445.22	$178.46
45160	T	Excision of rectal lesion	453	16.87	$892.28	$445.22	$178.46
45170	T	Excision of rectal lesion	453	16.87	$892.28	$445.22	$178.46
45190	T	Destruction, rectal tumor	453	16.87	$892.28	$445.22	$178.46
45300	T	Proctosigmoidoscopy	446	2.59	$137.12	$65.09	$27.42
45303	T	Proctosigmoidoscopy	447	6.87	$363.38	$184.87	$72.68
45305	T	Proctosigmoidoscopy; biopsy	446	2.59	$137.12	$65.09	$27.42
45307	T	Proctosigmoidoscopy	447	6.87	$363.38	$184.87	$72.68
45308	T	Proctosigmoidoscopy	447	6.87	$363.38	$184.87	$72.68
45309	T	Proctosigmoidoscopy	447	6.87	$363.38	$184.87	$72.68
45315	T	Proctosigmoidoscopy	447	6.87	$363.38	$184.87	$72.68
45317	T	Proctosigmoidoscopy	447	6.87	$363.38	$184.87	$72.68
45320	T	Proctosigmoidoscopy	447	6.87	$363.38	$184.87	$72.68
45321	T	Proctosigmoidoscopy	447	6.87	$363.38	$184.87	$72.68
45330	T	Sigmoidoscopy, diagnostic	446	2.59	$137.12	$65.09	$27.42
45331	T	Sigmoidoscopy and biopsy	446	2.59	$137.12	$65.09	$27.42
45332	T	Sigmoidoscopy	448	5.37	$284.04	$141.25	$56.81
45333	T	Sigmoidoscopy & polypectomy	448	5.37	$284.04	$141.25	$56.81
45334	T	Sigmoidoscopy for bleeding	448	5.37	$284.04	$141.25	$56.81
45337	T	Sigmoidoscopy, decompression	448	5.37	$284.04	$141.25	$56.81
45338	T	Sigmoidoscopy	448	5.37	$284.04	$141.25	$56.81

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
45339	T	Sigmoidoscopy	449	7.80	$412.35	$215.38	$82.47
45355	T	Surgical colonoscopy	427	8.22	$434.88	$224.19	$86.98
45378	T	Diagnostic colonoscopy	426	6.85	$362.40	$187.81	$72.48
45379	T	Colonoscopy	427	8.22	$434.88	$224.19	$86.98
45380	T	Colonoscopy and biopsy	426	6.85	$362.40	$187.81	$72.48
45382	T	Colonoscopy, control bleeding	427	8.22	$434.88	$224.19	$86.98
45383	T	Colonoscopy, lesion removal	449	7.80	$412.35	$215.38	$82.47
45384	T	Colonoscopy	427	8.22	$434.88	$224.19	$86.98
45385	T	Colonoscopy, lesion removal	427	8.22	$434.88	$224.19	$86.98
45500	T	Repair of rectum	453	16.87	$892.28	$445.22	$178.46
45505	T	Repair of rectum	453	16.87	$892.28	$445.22	$178.46
45520	T	Treatment of rectal prolapse	339	1.02	$53.87	$19.66	$10.77
45540	C	Correct rectal prolapse	.....	.....	.....	.....	.....
45541	C	Correct rectal prolapse	.....	.....	.....	.....	.....
45550	C	Repair rectum; remove sigmoid	.....	.....	.....	.....	.....
45560	T	Repair of rectocele	453	16.87	$892.28	$445.22	$178.46
45562	C	Exploration/repair of rectum	.....	.....	.....	.....	.....
45563	C	Exploration/repair of rectum	.....	.....	.....	.....	.....
45800	C	Repair rectumbladder fistula	.....	.....	.....	.....	.....
45805	C	Repair fistula; colostomy	.....	.....	.....	.....	.....
45820	C	Repair rectourethral fistula	.....	.....	.....	.....	.....
45825	C	Repair fistula; colostomy	.....	.....	.....	.....	.....
45900	T	Reduction of rectal prolapse	452	4.83	$255.64	$109.61	$51.13
45905	T	Dilation of anal sphincter	452	4.83	$255.64	$109.61	$51.13
45910	T	Dilation of rectal narrowing	452	4.83	$255.64	$109.61	$51.13
45915	T	Remove rectal obstruction	452	4.83	$255.64	$109.61	$51.13
45999	T	Rectum surgery procedure	452	4.83	$255.64	$109.61	$51.13
46030	T	Removal of rectal marker	452	4.83	$255.64	$109.61	$51.13
46040	T	Incision of rectal abscess	452	4.83	$255.64	$109.61	$51.13
46045	T	Incision of rectal abscess	453	16.87	$892.28	$445.22	$178.46
46050	T	Incision of anal abscess	452	4.83	$255.64	$109.61	$51.13
46060	T	Incision of rectal abscess	453	16.87	$892.28	$445.22	$178.46
46070	T	Incision of anal septum	451	2.56	$135.16	$54.24	$27.03
46080	T	Incision of anal sphincter	452	4.83	$255.64	$109.61	$51.13
46083	T	Incise external hemorrhoid	451	2.56	$135.16	$54.24	$27.03
46200	T	Removal of anal fissure	453	16.87	$892.28	$445.22	$178.46
46210	T	Removal of anal crypt	452	4.83	$255.64	$109.61	$51.13
46211	T	Removal of anal crypts	453	16.87	$892.28	$445.22	$178.46
46220	T	Removal of anal tab	451	2.56	$135.16	$54.24	$27.03
46221	T	Ligation of hemorrhoid(s)	451	2.56	$135.16	$54.24	$27.03
46230	T	Removal of anal tabs	451	2.56	$135.16	$54.24	$27.03
46250	T	Hemorrhoidectomy	453	16.87	$892.28	$445.22	$178.46
46255	T	Hemorrhoidectomy	453	16.87	$892.28	$445.22	$178.46
46257	T	Remove hemorrhoids & fissure	453	16.87	$892.28	$445.22	$178.46
46258	T	Remove hemorrhoids & fistula	453	16.87	$892.28	$445.22	$178.46
46260	T	Hemorrhoidectomy	453	16.87	$892.28	$445.22	$178.46
46261	T	Remove hemorrhoids & fissure	453	16.87	$892.28	$445.22	$178.46
46262	T	Remove hemorrhoids & fistula	453	16.87	$892.28	$445.22	$178.46
46270	T	Removal of anal fistula	453	16.87	$892.28	$445.22	$178.46
46275	T	Removal of anal fistula	453	16.87	$892.28	$445.22	$178.46
46280	T	Removal of anal fistula	453	16.87	$892.28	$445.22	$178.46
46285	T	Removal of anal fistula	453	16.87	$892.28	$445.22	$178.46
46288	T	Repair anal fistula	453	16.87	$892.28	$445.22	$178.46
46320	T	Removal of hemorrhoid clot	451	2.56	$135.16	$54.24	$27.03
46500	T	Injection into hemorrhoids	451	2.56	$135.16	$54.24	$27.03
46600	N	Diagnostic anoscopy	.....	.....	.....	.....	.....
46604	N	Anoscopy and dilation	.....	.....	.....	.....	.....
46606	T	Anoscopy and biopsy	436	1.43	$75.42	$24.86	$15.08
46608	T	Anoscopy; remove foreign body	437	2.91	$153.77	$76.61	$30.75
46610	T	Anoscopy; remove lesion	437	2.91	$153.77	$76.61	$30.75
46611	T	Anoscopy	437	2.91	$153.77	$76.61	$30.75
46612	T	Anoscopy; remove lesions	437	2.91	$153.77	$76.61	$30.75
46614	T	Anoscopy; control bleeding	437	2.91	$153.77	$76.61	$30.75
46615	T	Anoscopy	437	2.91	$153.77	$76.61	$30.75
46700	T	Repair of anal stricture	453	16.87	$892.28	$445.22	$178.46
46705	C	Repair of anal stricture	.....	.....	.....	.....	.....
46715	C	Repair of anovaginal fistula	.....	.....	.....	.....	.....
46716	C	Repair of anovaginal fistula	.....	.....	.....	.....	.....
46730	C	Construction of absent anus	.....	.....	.....	.....	.....
46735	C	Construction of absent anus	.....	.....	.....	.....	.....
46740	C	Construction of absent anus	.....	.....	.....	.....	.....
46742	C	Repair, imperforated anus	.....	.....	.....	.....	.....
46744	C	Repair, cloacal anomaly	.....	.....	.....	.....	.....
46746	C	Repair, cloacal anomaly	.....	.....	.....	.....	.....
46748	C	Repair, cloacal anomaly	.....	.....	.....	.....	.....

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
46750	T	Repair of anal sphincter	453	16.87	$892.28	$445.22	$178.46
46751	C	Repair of anal sphincter					
46753	T	Reconstruction of anus	453	16.87	$892.28	$445.22	$178.46
46754	T	Removal of suture from anus	452	4.83	$255.64	$109.61	$51.13
46760	T	Repair of anal sphincter	453	16.87	$892.28	$445.22	$178.46
46761	T	Repair of anal sphincter	453	16.87	$892.28	$445.22	$178.46
46762	T	Implant artificial sphincter	453	16.87	$892.28	$445.22	$178.46
46900	T	Destruction, anal lesion(s)	152	10.43	$551.43	$261.71	$110.29
46910	T	Destruction, anal lesion(s)	152	10.43	$551.43	$261.71	$110.29
46916	T	Cryosurgery, anal lesion(s)	152	10.43	$551.43	$261.71	$110.29
46917	T	Laser surgery, anal lesion(s)	152	10.43	$551.43	$261.71	$110.29
46922	T	Excision of anal lesion(s)	152	10.43	$551.43	$261.71	$110.29
46924	T	Destruction, anal lesion(s)	152	10.43	$551.43	$261.71	$110.29
46934	T	Destruction of hemorrhoids	451	2.56	$135.16	$54.24	$27.03
46935	T	Destruction of hemorrhoids	451	2.56	$135.16	$54.24	$27.03
46936	T	Destruction of hemorrhoids	451	2.56	$135.16	$54.24	$27.03
46937	T	Cryotherapy of rectal lesion	453	16.87	$892.28	$445.22	$178.46
46938	T	Cryotherapy of rectal lesion	453	16.87	$892.28	$445.22	$178.46
46940	T	Treatment of anal fissure	451	2.56	$135.16	$54.24	$27.03
46942	T	Treatment of anal fissure	451	2.56	$135.16	$54.24	$27.03
46945	T	Ligation of hemorrhoids	451	2.56	$135.16	$54.24	$27.03
46946	T	Ligation of hemorrhoids	451	2.56	$135.16	$54.24	$27.03
46999	T	Anus surgery procedure	452	4.83	$255.64	$109.61	$51.13
47000	T	Needle biopsy of liver	122	4.87	$257.60	$115.03	$51.52
47001	C	Needle biopsy, liver					
47010	C	Open drainage, liver lesion					
47011	C	Percut drain, liver lesion					
47015	C	Inject/aspirate liver cyst					
47100	C	Wedge biopsy of liver					
47120	C	Partial removal of liver					
47122	C	Extensive removal of liver					
47125	C	Partial removal of liver					
47130	C	Partial removal of liver					
47133	C	Removal of donor liver					
47134	C	Partial removal, donor liver					
47135	C	Transplantation of liver					
47136	C	Transplantation of liver					
47300	C	Surgery for liver lesion					
47350	C	Repair liver wound					
47360	C	Repair liver wound					
47361	C	Repair liver wound					
47362	C	Repair liver wound					
47399	T	Liver surgery procedure	122	4.87	$257.60	$115.03	$51.52
47400	C	Incision of liver duct					
47420	C	Incision of bile duct					
47425	C	Incision of bile duct					
47460	C	Incise bile duct sphincter					
47480	C	Incision of gallbladder					
47490	C	Incision of gallbladder					
47500	T	Injection for liver x-rays	347	2.93	$154.75	$62.15	$30.95
47505	T	Injection for liver x-rays	347	2.93	$154.75	$62.15	$30.95
47510	T	Insert catheter, bile duct	458	7.24	$382.97	$181.70	$76.59
47511	T	Insert bile duct drain	458	7.24	$382.97	$181.70	$76.59
47525	T	Change bile duct catheter	470	2.22	$117.53	$54.92	$23.51
47530	T	Revise, reinsert bile tube	470	2.22	$117.53	$54.92	$23.51
47550	C	Bile duct endoscopy					
47552	T	Biliary endoscopy, thru skin	458	7.24	$382.97	$181.70	$76.59
47553	T	Biliary endoscopy, thru skin	458	7.24	$382.97	$181.70	$76.59
47554	T	Biliary endoscopy, thru skin	458	7.24	$382.97	$181.70	$76.59
47555	T	Biliary endoscopy, thru skin	458	7.24	$382.97	$181.70	$76.59
47556	T	Biliary endoscopy, thru skin	458	7.24	$382.97	$181.70	$76.59
47600	C	Removal of gallbladder					
47605	C	Removal of gallbladder					
47610	C	Removal of gallbladder					
47612	C	Removal of gallbladder					
47620	C	Removal of gallbladder					
47630	T	Remove bile duct stone	458	7.24	$382.97	$181.70	$76.59
47700	C	Exploration of bile ducts					
47701	C	Bile duct revision					
47711	C	Excision of bile duct tumor					
47712	C	Excision of bile duct tumor					
47715	C	Excision of bile duct cyst					
47716	C	Fusion of bile duct cyst					
47720	C	Fuse gallbladder & bowel					
47721	C	Fuse upper gi structures					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
47740	C	Fuse gallbladder & bowel					
47741	C	Fuse gallbladder & bowel					
47760	C	Fuse bile ducts and bowel					
47765	C	Fuse liver ducts & bowel					
47780	C	Fuse bile ducts and bowel					
47785	C	Fuse bile ducts and bowel					
47800	C	Reconstruction of bile ducts					
47801	C	Placement, bile duct support					
47802	C	Fuse liver duct & intestine					
47900	C	Suture bile duct injury					
47999	T	Bile tract surgery procedure	470	2.22	$117.53	$54.92	$23.51
48000	C	Drainage of abdomen					
48001	C	Placement of drain, pancreas					
48005	C	Resect/debride pancreas					
48020	C	Removal of pancreatic stone					
48100	C	Biopsy of pancreas					
48102	T	Needle biopsy, pancreas	122	4.87	$257.60	$115.03	$51.52
48120	C	Removal of pancreas lesion					
48140	C	Partial removal of pancreas					
48145	C	Partial removal of pancreas					
48146	C	Pancreatectomy					
48148	C	Removal of pancreatic duct					
48150	C	Partial removal of pancreas					
48152	C	Pancreatectomy					
48153	C	Pancreatectomy					
48154	C	Pancreatectomy					
48155	C	Removal of pancreas					
48160	E	Pancreas removal, transplant					
48180	C	Fuse pancreas and bowel					
48400	C	Injection, intraoperative					
48500	C	Surgery of pancreas cyst					
48510	C	Drain pancreatic pseudocyst					
48511	C	Drain pancreatic pseudocyst					
48520	C	Fuse pancreas cyst and bowel					
48540	C	Fuse pancreas cyst and bowel					
48545	C	Pancreatorrhaphy					
48547	C	Duodenal exclusion					
48550	E	Donor pancreatectomy					
48554	E	Transplantallograft pancreas					
48556	C	Removal, allograft pancreas					
48999	T	Pancreas surgery procedure	122	4.87	$257.60	$115.03	$51.52
49000	C	Exploration of abdomen					
49002	C	Reopening of abdomen					
49010	C	Exploration behind abdomen					
49020	C	Drain abdominal abscess					
49021	C	Drain abdominal abscess					
49040	C	Open drainage abdom abscess					
49041	C	Percut drain abdom abscess					
49060	C	Open drain retroper abscess					
49061	C	Percutdrain retroper abscess					
49062	C	Drain to peritoneal cavity					
49080	T	Puncture, peritoneal cavity	320	3.17	$167.49	$79.33	$33.50
49081	T	Removal of abdominal fluid	320	3.17	$167.49	$79.33	$33.50
49085	T	Remove abdomen foreign body	459	18.06	$954.97	$496.52	$190.99
49180	T	Biopsy, abdominal mass	122	4.87	$257.60	$115.03	$51.52
49200	C	Removal of abdominal lesion					
49201	C	Removal of abdominal lesion					
49215	C	Excise sacral spine tumor					
49220	C	Multiple surgery, abdomen					
49250	T	Excision of umbilicus	459	18.06	$954.97	$496.52	$190.99
49255	C	Removal of omentum					
49400	T	Air injection into abdomen	347	2.93	$154.75	$62.15	$30.95
49420	T	Insert abdominal drain	459	18.06	$954.97	$496.52	$190.99
49421	T	Insert abdominal drain	459	18.06	$954.97	$496.52	$190.99
49422	T	Remove perm cannula/catheter	470	2.22	$117.53	$54.92	$23.51
49423	T	Exchange drainage cath	459	18.06	$954.97	$496.52	$190.99
49424	T	Assess cyst, contrast inj	347	2.93	$154.75	$62.15	$30.95
49425	C	Insert abdomen-venous drain					
49426	T	Revise abdomen-venous shunt	459	18.06	$954.97	$496.52	$190.99
49427	T	Injection, abdominal shunt	347	2.93	$154.75	$62.15	$30.95
49428	C	Ligation of shunt					
49429	T	Removal of shunt	470	2.22	$117.53	$54.92	$23.51
49495	T	Repair inguinal hernia, init	466	21.43	$1,133.23	$562.97	$226.65
49496	T	Repair inguinal hernia, init	466	21.43	$1,133.23	$562.97	$226.65
49500	T	Repair inguinal hernia	466	21.43	$1,133.23	$562.97	$226.65

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
49501	T	Repair inguinal hernia, init	466	21.43	$1,133.23	$562.97	$226.65
49505	T	Repair inguinal hernia	466	21.43	$1,133.23	$562.97	$226.65
49507	T	Repair, inguinal hernia	466	21.43	$1,133.23	$562.97	$226.65
49520	T	Rerepair inguinal hernia	466	21.43	$1,133.23	$562.97	$226.65
49521	T	Repair inguinal hernia, rec	466	21.43	$1,133.23	$562.97	$226.65
49525	T	Repair inguinal hernia	466	21.43	$1,133.23	$562.97	$226.65
49540	T	Repair lumbar hernia	466	21.43	$1,133.23	$562.97	$226.65
49550	T	Repair femoral hernia	466	21.43	$1,133.23	$562.97	$226.65
49553	T	Repair femoral hernia, init	466	21.43	$1,133.23	$562.97	$226.65
49555	T	Repair femoral hernia	466	21.43	$1,133.23	$562.97	$226.65
49557	T	Repair femoral hernia, recur	466	21.43	$1,133.23	$562.97	$226.65
49560	T	Repair abdominal hernia	466	21.43	$1,133.23	$562.97	$226.65
49561	T	Repair incisional hernia	466	21.43	$1,133.23	$562.97	$226.65
49565	T	Rerepair abdominal hernia	466	21.43	$1,133.23	$562.97	$226.65
49566	T	Repair incisional hernia	466	21.43	$1,133.23	$562.97	$226.65
49568	T	Hernia repair w/mesh	466	21.43	$1,133.23	$562.97	$226.65
49570	T	Repair epigastric hernia	466	21.43	$1,133.23	$562.97	$226.65
49572	T	Repair, epigastric hernia	466	21.43	$1,133.23	$562.97	$226.65
49580	T	Repair umbilical hernia	466	21.43	$1,133.23	$562.97	$226.65
49582	T	Repair umbilical hernia	466	21.43	$1,133.23	$562.97	$226.65
49585	T	Repair umbilical hernia	466	21.43	$1,133.23	$562.97	$226.65
49587	T	Repair umbilical hernia	466	21.43	$1,133.23	$562.97	$226.65
49590	T	Repair abdominal hernia	466	21.43	$1,133.23	$562.97	$226.65
49600	T	Repair umbilical lesion	466	21.43	$1,133.23	$562.97	$226.65
49605	C	Repair umbilical lesion					
49606	C	Repair umbilical lesion					
49610	C	Repair umbilical lesion					
49611	C	Repair umbilical lesion					
49900	C	Repair of abdominal wall					
49905	C	Omental flap					
49906	C	Free omental flap, microvasc					
49999	T	Abdomen surgery procedure	470	2.22	$117.53	$54.92	$23.51
50010	C	Exploration of kidney					
50020	C	Open drain renal abscess					
50021	C	Percut drain renal abscess					
50040	C	Drainage of kidney					
50045	C	Exploration of kidney					
50060	C	Removal of kidney stone					
50065	C	Incision of kidney					
50070	C	Incision of kidney					
50075	C	Removal of kidney stone					
50080	C	Removal of kidney stone					
50081	C	Removal of kidney stone					
50100	C	Revise kidney blood vessels					
50120	C	Exploration of kidney					
50125	C	Explore and drain kidney					
50130	C	Removal of kidney stone					
50135	C	Exploration of kidney					
50200	T	Biopsy of kidney	122	4.87	$257.60	$115.03	$51.52
50205	C	Biopsy of kidney					
50220	C	Removal of kidney					
50225	C	Removal of kidney					
50230	C	Removal of kidney					
50234	C	Removal of kidney & ureter					
50236	C	Removal of kidney & ureter					
50240	C	Partial removal of kidney					
50280	C	Removal of kidney lesion					
50290	C	Removal of kidney lesion					
50300	C	Removal of donor kidney					
50320	C	Removal of donor kidney					
50340	C	Removal of kidney					
50360	C	Transplantation of kidney					
50365	C	Transplantation of kidney					
50370	C	Remove transplanted kidney					
50380	C	Reimplantation of kidney					
50390	T	Drainage of kidney lesion	122	4.87	$257.60	$115.03	$51.52
50392	T	Insert kidney drain	347	2.93	$154.75	$62.15	$30.95
50393	T	Insert ureteral tube	347	2.93	$154.75	$62.15	$30.95
50394	T	Injection for kidney x-ray	347	2.93	$154.75	$62.15	$30.95
50395	T	Create passage to kidney	347	2.93	$154.75	$62.15	$30.95
50396	T	Measure kidney pressure	529	2.50	$132.23	$63.05	$26.45
50398	T	Change kidney tube	521	5.06	$267.39	$112.10	$53.48
50400	C	Revision of kidney/ureter					
50405	C	Revision of kidney/ureter					
50500	C	Repair of kidney wound					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
50520	C	Close kidney-skin fistula					
50525	C	Repair renal-abdomen fistula					
50526	C	Repair renal-abdomen fistula					
50540	C	Revision of horseshoe kidney					
50551	T	Kidney endoscopy	522	10.46	$553.39	$262.39	$110.68
50553	T	Kidney endoscopy	522	10.46	$553.39	$262.39	$110.68
50555	T	Kidney endoscopy & biopsy	522	10.46	$553.39	$262.39	$110.68
50557	T	Kidney endoscopy & treatment	522	10.46	$553.39	$262.39	$110.68
50559	T	Renal endoscopy; radiotracer	522	10.46	$553.39	$262.39	$110.68
50561	T	Kidney endoscopy & treatment	522	10.46	$553.39	$262.39	$110.68
50570	C	Kidney endoscopy					
50572	C	Kidney endoscopy					
50574	C	Kidney endoscopy & biopsy					
50575	C	Kidney endoscopy					
50576	C	Kidney endoscopy & treatment					
50578	C	Renal endoscopy; radiotracer					
50580	C	Kidney endoscopy & treatment					
50590	T	Fragmenting of kidney stone	527	51.56	$2,726.80	$1,372.95	$545.36
50600	C	Exploration of ureter					
50605	C	Insert ureteral support					
50610	C	Removal of ureter stone					
50620	C	Removal of ureter stone					
50630	C	Removal of ureter stone					
50650	C	Removal of ureter					
50660	C	Removal of ureter					
50684	T	Injection for ureter x-ray	347	2.93	$154.75	$62.15	$30.95
50686	T	Measure ureter pressure	529	2.50	$132.23	$63.05	$26.45
50688	T	Change of ureter tube	470	2.22	$117.53	$54.92	$23.51
50690	T	Injection for ureter x-ray	347	2.93	$154.75	$62.15	$30.95
50700	C	Revision of ureter					
50715	C	Release of ureter					
50722	C	Release of ureter					
50725	C	Release/revise ureter					
50727	C	Revise ureter					
50728	C	Revise ureter					
50740	C	Fusion of ureter & kidney					
50750	C	Fusion of ureter & kidney					
50760	C	Fusion of ureters					
50770	C	Splicing of ureters					
50780	C	Reimplant ureter in bladder					
50782	C	Reimplant ureter in bladder					
50783	C	Reimplant ureter in bladder					
50785	C	Reimplant ureter in bladder					
50800	C	Implant ureter in bowel					
50810	C	Fusion of ureter & bowel					
50815	C	Urine shunt to bowel					
50820	C	Construct bowel bladder					
50825	C	Construct bowel bladder					
50830	C	Revise urine flow					
50840	C	Replace ureter by bowel					
50845	C	Appendico-vesicostomy					
50860	C	Transplant ureter to skin					
50900	C	Repair of ureter					
50920	C	Closure ureter/skin fistula					
50930	C	Closure ureter/bowel fistula					
50940	C	Release of ureter					
50951	T	Endoscopy of ureter	523	16.87	$892.28	$447.03	$178.46
50953	T	Endoscopy of ureter	523	16.87	$892.28	$447.03	$178.46
50955	T	Ureter endoscopy & biopsy	523	16.87	$892.28	$447.03	$178.46
50957	T	Ureter endoscopy & treatment	523	16.87	$892.28	$447.03	$178.46
50959	T	Ureter endoscopy & tracer	523	16.87	$892.28	$447.03	$178.46
50961	T	Ureter endoscopy & treatment	523	16.87	$892.28	$447.03	$178.46
50970	C	Ureter endoscopy					
50972	C	Ureter endoscopy & catheter					
50974	C	Ureter endoscopy & biopsy					
50976	C	Ureter endoscopy & treatment					
50978	C	Ureter endoscopy & tracer					
50980	C	Ureter endoscopy & treatment					
51000	T	Drainage of bladder	530	2.52	$133.21	$54.69	$26.64
51005	T	Drainage of bladder	530	2.52	$133.21	$54.69	$26.64
51010	T	Drainage of bladder	530	2.52	$133.21	$54.69	$26.64
51020	T	Incise & treat bladder	523	16.87	$892.28	$447.03	$178.46
51030	T	Incise & treat bladder	523	16.87	$892.28	$447.03	$178.46
51040	T	Incise & drain bladder	523	16.87	$892.28	$447.03	$178.46
51045	T	Incise bladder, drain ureter	523	16.87	$892.28	$447.03	$178.46

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
51050	T	Removal of bladder stone	523	16.87	$892.28	$447.03	$178.46
51060	C	Removal of ureter stone					
51065	T	Removal of ureter stone	523	16.87	$892.28	$447.03	$178.46
51080	T	Drainage of bladder abscess	132	6.04	$319.30	$134.24	$63.86
51500	T	Removal of bladder cyst	466	21.43	$1,133.23	$562.97	$226.65
51520	T	Removal of bladder lesion	523	16.87	$892.28	$447.03	$178.46
51525	C	Removal of bladder lesion					
51530	C	Removal of bladder lesion					
51535	C	Repair of ureter lesion					
51550	C	Partial removal of bladder					
51555	C	Partial removal of bladder					
51565	C	Revise bladder & ureter(s)					
51570	C	Removal of bladder					
51575	C	Removal of bladder & nodes					
51580	C	Remove bladder; revise tract					
51585	C	Removal of bladder & nodes					
51590	C	Remove bladder; revise tract					
51595	C	Remove bladder; revise tract					
51596	C	Remove bladder, create pouch					
51597	C	Removal of pelvic structures					
51600	T	Injection for bladder x-ray	347	2.93	$154.75	$62.15	$30.95
51605	T	Preparation for bladder xray	347	2.93	$154.75	$62.15	$30.95
51610	T	Injection for bladder x-ray	347	2.93	$154.75	$62.15	$30.95
51700	T	Irrigation of bladder	530	2.52	$133.21	$54.69	$26.64
51705	T	Change of bladder tube	470	2.22	$117.53	$54.92	$23.51
51710	T	Change of bladder tube	470	2.22	$117.53	$54.92	$23.51
51715	T	Endoscopic injection/implant	531	18.94	$1,001.98	$527.26	$200.40
51720	T	Treatment of bladder lesion	530	2.52	$133.21	$54.69	$26.64
51725	T	Simple cystometrogram	529	2.50	$132.23	$63.05	$26.45
51726	T	Complex cystometrogram	529	2.50	$132.23	$63.05	$26.45
51736	T	Urine flow measurement	529	2.50	$132.23	$63.05	$26.45
51741	T	Electro-uroflowmetry, first	529	2.50	$132.23	$63.05	$26.45
51772	T	Urethra pressure profile	529	2.50	$132.23	$63.05	$26.45
51784	T	Anal/urinary muscle study	529	2.50	$132.23	$63.05	$26.45
51785	T	Anal/urinary muscle study	529	2.50	$132.23	$63.05	$26.45
51792	T	Urinary reflex study	529	2.50	$132.23	$63.05	$26.45
51795	T	Urine voiding pressure study	529	2.50	$132.23	$63.05	$26.45
51797	T	Intraabdominal pressure test	529	2.50	$132.23	$63.05	$26.45
51800	C	Revision of bladder/urethra					
51820	C	Revision of urinary tract					
51840	C	Attach bladder/urethra					
51841	C	Attach bladder/urethra					
51845	C	Repair bladder neck					
51860	C	Repair of bladder wound					
51865	C	Repair of bladder wound					
51880	T	Repair of bladder opening	523	16.87	$892.28	$447.03	$178.46
51900	C	Repair bladder/vagina lesion					
51920	C	Close bladder-uterus fistula					
51925	C	Hysterectomy/bladder repair					
51940	C	Correction of bladder defect					
51960	C	Revision of bladder & bowel					
51980	C	Construct bladder opening					
52000	T	Cystoscopy	521	5.06	$267.39	$112.10	$53.48
52005	T	Cystoscopy & ureter catheter	522	10.46	$553.39	$262.39	$110.68
52007	T	Cystoscopy and biopsy	522	10.46	$553.39	$262.39	$110.68
52010	T	Cystoscopy & duct catheter	522	10.46	$553.39	$262.39	$110.68
52204	T	Cystoscopy	522	10.46	$553.39	$262.39	$110.68
52214	T	Cystoscopy and treatment	522	10.46	$553.39	$262.39	$110.68
52224	T	Cystoscopy and treatment	522	10.46	$553.39	$262.39	$110.68
52234	T	Cystoscopy and treatment	523	16.87	$892.28	$447.03	$178.46
52235	T	Cystoscopy and treatment	523	16.87	$892.28	$447.03	$178.46
52240	T	Cystoscopy and treatment	523	16.87	$892.28	$447.03	$178.46
52250	T	Cystoscopy & radiotracer	523	16.87	$892.28	$447.03	$178.46
52260	T	Cystoscopy & treatment	522	10.46	$553.39	$262.39	$110.68
52265	T	Cystoscopy & treatment	521	5.06	$267.39	$112.10	$53.48
52270	T	Cystoscopy & revise urethra	522	10.46	$553.39	$262.39	$110.68
52275	T	Cystoscopy & revise urethra	522	10.46	$553.39	$262.39	$110.68
52276	T	Cystoscopy and treatment	522	10.46	$553.39	$262.39	$110.68
52277	T	Cystoscopy and treatment	523	16.87	$892.28	$447.03	$178.46
52281	T	Cystoscopy and treatment	522	10.46	$553.39	$262.39	$110.68
52282	T	Cystoscopy, implant stent	523	16.87	$892.28	$447.03	$178.46
52283	T	Cystoscopy and treatment	522	10.46	$553.39	$262.39	$110.68
52285	T	Cystoscopy and treatment	522	10.46	$553.39	$262.39	$110.68
52290	T	Cystoscopy and treatment	522	10.46	$553.39	$262.39	$110.68
52300	T	Cystoscopy and treatment	522	10.46	$553.39	$262.39	$110.68

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
52301	T	Cystoscopy and treatment	522	10.46	$553.39	$262.39	$110.68
52305	T	Cystoscopy and treatment	522	10.46	$553.39	$262.39	$110.68
52310	T	Cystoscopy and treatment	522	10.46	$553.39	$262.39	$110.68
52315	T	Cystoscopy and treatment	522	10.46	$553.39	$262.39	$110.68
52317	T	Remove bladder stone	523	16.87	$892.28	$447.03	$178.46
52318	T	Remove bladder stone	523	16.87	$892.28	$447.03	$178.46
52320	T	Cystoscopy and treatment	523	16.87	$892.28	$447.03	$178.46
52325	T	Cystoscopy, stone removal	523	16.87	$892.28	$447.03	$178.46
52327	T	Cystoscopy, inject material	522	10.46	$553.39	$262.39	$110.68
52330	T	Cystoscopy and treatment	523	16.87	$892.28	$447.03	$178.46
52332	T	Cystoscopy and treatment	523	16.87	$892.28	$447.03	$178.46
52334	T	Create passage to kidney	523	16.87	$892.28	$447.03	$178.46
52335	T	Endoscopy of urinary tract	523	16.87	$892.28	$447.03	$178.46
52336	T	Cystoscopy, stone removal	523	16.87	$892.28	$447.03	$178.46
52337	T	Cystoscopy, stone removal	524	28.89	1,527.95	$833.49	$305.59
52338	T	Cystoscopy and treatment	523	16.87	$892.28	$447.03	$178.46
52339	T	Cystoscopy and treatment	523	16.87	$892.28	$447.03	$178.46
52340	T	Cystoscopy and treatment	523	16.87	$892.28	$447.03	$178.46
52450	T	Incision of prostate	523	16.87	$892.28	$447.03	$178.46
52500	T	Revision of bladder neck	523	16.87	$892.28	$447.03	$178.46
52510	T	Dilation prostatic urethra	522	10.46	$553.39	$262.39	$110.68
52601	T	Prostatectomy (TURP)	524	28.89	$1,527.95	$833.49	$305.59
52606	T	Control postop bleeding	523	16.87	$892.28	$447.03	$178.46
52612	T	Prostatectomy, first stage	524	28.89	$1,527.95	$833.49	$305.59
52614	T	Prostatectomy, second stage	524	28.89	$1,527.95	$833.49	$305.59
52620	T	Remove residual prostate	524	28.89	$1,527.95	$833.49	$305.59
52630	T	Remove prostate regrowth	524	28.89	$1,527.95	$833.49	$305.59
52640	T	Relieve bladder contracture	523	16.87	$892.28	$447.03	$178.46
52647	T	Laser surgery of prostate	524	28.89	$1,527.95	$833.49	$305.59
52648	T	Laser surgery of prostate	524	28.89	$1,527.95	$833.49	$305.59
52700	T	Drainage of prostate abscess	523	16.87	$892.28	$447.03	$178.46
53000	T	Incision of urethra	531	18.94	$1,001.98	$527.26	$200.40
53010	T	Incision of urethra	531	18.94	$1,001.98	$527.26	$200.40
53020	T	Incision of urethra	531	18.94	$1,001.98	$527.26	$200.40
53025	T	Incision of urethra	531	18.94	$1,001.98	$527.26	$200.40
53040	T	Drainage of urethra abscess	531	18.94	$1,001.98	$527.26	$200.40
53060	T	Drainage of urethra abscess	531	18.94	$1,001.98	$527.26	$200.40
53080	T	Drainage of urinary leakage	531	18.94	$1,001.98	$527.26	$200.40
53085	C	Drainage of urinary leakage	.....	.....	.....	.....	.....
53200	T	Biopsy of urethra	531	18.94	$1,001.98	$527.26	$200.40
53210	T	Removal of urethra	532	25.50	$1,348.71	$602.29	$269.74
53215	T	Removal of urethra	532	25.50	$1,348.71	$602.29	$269.74
53220	T	Treatment of urethra lesion	532	25.50	$1,348.71	$602.29	$269.74
53230	T	Removal of urethra lesion	532	25.50	$1,348.71	$602.29	$269.74
53235	T	Removal of urethra lesion	532	25.50	$1,348.71	$602.29	$269.74
53240	T	Surgery for urethra pouch	532	25.50	$1,348.71	$602.29	$269.74
53250	T	Removal of urethra gland	531	18.94	$1,001.98	$527.26	$200.40
53260	T	Treatment of urethra lesion	531	18.94	$1,001.98	$527.26	$200.40
53265	T	Treatment of urethra lesion	531	18.94	$1,001.98	$527.26	$200.40
53270	T	Removal of urethra gland	531	18.94	$1,001.98	$527.26	$200.40
53275	T	Repair of urethra defect	531	18.94	$1,001.98	$527.26	$200.40
53400	T	Revise urethra, 1st stage	532	25.50	$1,348.71	$602.29	$269.74
53405	T	Revise urethra, 2nd stage	532	25.50	$1,348.71	$602.29	$269.74
53410	T	Reconstruction of urethra	532	25.50	$1,348.71	$602.29	$269.74
53415	C	Reconstruction of urethra	.....	.....	.....	.....	.....
53420	T	Reconstruct urethra, stage 1	532	25.50	$1,348.71	$602.29	$269.74
53425	T	Reconstruct urethra, stage 2	532	25.50	$1,348.71	$602.29	$269.74
53430	T	Reconstruction of urethra	532	25.50	$1,348.71	$602.29	$269.74
53440	T	Correct bladder function	538	45.59	$2,411.41	$1,540.64	$482.28
53442	T	Remove perineal prosthesis	531	18.94	$1,001.98	$527.26	$200.40
53443	C	Reconstruction of urethra	.....	.....	.....	.....	.....
53445	T	Correct urine flow control	538	45.59	$2,411.41	$1,540.64	$482.28
53447	T	Remove artificial sphincter	532	25.50	$1,348.71	$602.29	$269.74
53449	T	Correct artificial sphincter	532	25.50	$1,348.71	$602.29	$269.74
53450	T	Revision of urethra	532	25.50	$1,348.71	$602.29	$269.74
53460	T	Revision of urethra	532	25.50	$1,348.71	$602.29	$269.74
53502	T	Repair of urethra injury	531	18.94	$1,001.98	$527.26	$200.40
53505	T	Repair of urethra injury	531	18.94	$1,001.98	$527.26	$200.40
53510	T	Repair of urethra injury	531	18.94	$1,001.98	$527.26	$200.40
53515	T	Repair of urethra injury	532	25.50	$1,348.71	$602.29	$269.74
53520	T	Repair of urethra defect	532	25.50	$1,348.71	$602.29	$269.74
53600	T	Dilate urethra stricture	530	2.52	$133.21	$54.69	$26.64
53601	T	Dilate urethra stricture	530	2.52	$133.21	$54.69	$26.64
53605	T	Dilate urethra stricture	522	10.46	$553.39	$262.39	$110.68
53620	T	Dilate urethra stricture	530	2.52	$133.21	$54.69	$26.64

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
53621	T	Dilate urethra stricture	530	2.52	$133.21	$54.69	$26.64
53660	T	Dilation of urethra	530	2.52	$133.21	$54.69	$26.64
53661	T	Dilation of urethra	530	2.52	$133.21	$54.69	$26.64
53665	T	Dilation of urethra	531	18.94	$1,001.98	$527.26	$200.4
53670	N	Insert urinary catheter	.....	.....	.....	.....	.....
53675	T	Insert urinary catheter	530	2.52	$133.21	$54.69	$26.64
53850	T	Prostatic microwave thermotx	524	28.89	$1,527.95	$833.49	$305.59
53852	T	Prostatic rf thermotx	524	28.89	$1,527.95	$833.49	$305.59
53899	T	Urology surgery procedure	530	2.52	$133.21	$54.69	$26.64
54000	T	Slitting of prepuce	531	18.94	$1,001.98	$527.26	$200.4
54001	T	Slitting of prepuce	531	18.94	$1,001.98	$527.26	$200.4
54015	T	Drain penis lesion	132	6.04	$319.3	$134.24	$63.86
54050	T	Destruction, penis lesion(s)	152	10.43	$551.43	$261.71	$110.29
54055	T	Destruction, penis lesion(s)	152	10.43	$551.43	$261.71	$110.29
54056	T	Cryosurgery, penis lesion(s)	152	10.43	$551.43	$261.71	$110.29
54057	T	Laser surg, penis lesion(s)	152	10.43	$551.43	$261.71	$110.29
54060	T	Excision of penis lesion(s)	152	10.43	$551.43	$261.71	$110.29
54065	T	Destruction, penis lesion(s)	152	10.43	$551.43	$261.71	$110.29
54100	T	Biopsy of penis	162	5.67	$299.71	$125.43	$59.94
54105	T	Biopsy of penis	162	5.67	$299.71	$125.43	$59.94
54110	T	Treatment of penis lesion	537	28.72	$1,519.13	$864.45	$303.83
54111	T	Treat penis lesion, graft	537	28.72	$1,519.13	$864.45	$303.83
54112	T	Treat penis lesion, graft	537	28.72	$1,519.13	$864.45	$303.83
54115	T	Treatment of penis lesion	132	6.04	$319.3	$134.24	$63.86
54120	T	Partial removal of penis	537	28.72	$1,519.13	$864.45	$303.83
54125	C	Removal of penis	.....	.....	.....	.....	.....
54130	C	Remove penis & nodes	.....	.....	.....	.....	.....
54135	C	Remove penis & nodes	.....	.....	.....	.....	.....
54150	T	Circumcision	536	13.17	$696.39	$326.57	$139.28
54152	T	Circumcision	536	13.17	$696.39	$326.57	$139.28
54160	T	Circumcision	536	13.17	$696.39	$326.57	$139.28
54161	T	Circumcision	536	13.17	$696.39	$326.57	$139.28
54200	T	Treatment of penis lesion	530	2.52	$133.21	$54.69	$26.64
54205	T	Treatment of penis lesion	537	28.72	$1,519.13	$864.45	$303.83
54220	T	Treatment of penis lesion	530	2.52	$133.21	$54.69	$26.64
54230	T	Prepare penis study	347	2.93	$154.75	$62.15	$30.95
54231	T	Dynamic cavernosometry	530	2.52	$133.21	$54.69	$26.64
54235	T	Penile injection	530	2.52	$133.21	$54.69	$26.64
54240	T	Penis study	529	2.50	$132.23	$63.05	$26.45
54250	T	Penis study	529	2.50	$132.23	$63.05	$26.45
54300	T	Revision of penis	537	28.72	$1,519.13	$864.45	$303.83
54304	T	Revision of penis	537	28.72	$1,519.13	$864.45	$303.83
54308	T	Reconstruction of urethra	537	28.72	$1,519.13	$864.45	$303.83
54312	T	Reconstruction of urethra	537	28.72	$1,519.13	$864.45	$303.83
54316	T	Reconstruction of urethra	537	28.72	$1,519.13	$864.45	$303.83
54318	T	Reconstruction of urethra	537	28.72	$1,519.13	$864.45	$303.83
54322	T	Reconstruction of urethra	537	28.72	$1,519.13	$864.45	$303.83
54324	T	Reconstruction of urethra	537	28.72	$1,519.13	$864.45	$303.83
54326	T	Reconstruction of urethra	537	28.72	$1,519.13	$864.45	$303.83
54328	T	Revise penis, urethra	537	28.72	$1,519.13	$864.45	$303.83
54332	C	Revise penis, urethra	.....	.....	.....	.....	.....
54336	C	Revise penis, urethra	.....	.....	.....	.....	.....
54340	T	Secondary urethral surgery	537	28.72	$1,519.13	$864.45	$303.83
54344	T	Secondary urethral surgery	537	28.72	$1,519.13	$864.45	$303.83
54348	T	Secondary urethral surgery	537	28.72	$1,519.13	$864.45	$303.83
54352	T	Reconstruct urethra, penis	537	28.72	$1,519.13	$864.45	$303.83
54360	T	Penis plastic surgery	537	28.72	$1,519.13	$864.45	$303.83
54380	T	Repair penis	537	28.72	$1,519.13	$864.45	$303.83
54385	T	Repair penis	537	28.72	$1,519.13	$864.45	$303.83
54390	C	Repair penis and bladder	.....	.....	.....	.....	.....
54400	T	Insert semi-rigid prosthesis	538	45.59	$2,411.41	$1,540.64	$482.28
54401	T	Insert self-contd prosthesis	538	45.59	$2,411.41	$1,540.64	$482.28
54402	T	Remove penis prosthesis	537	28.72	$1,519.13	$864.45	$303.83
54405	T	Insert multi-comp prosthesis	538	45.59	$2,411.41	$1,540.64	$482.28
54407	T	Remove multi-comp prosthesis	537	28.72	$1,519.13	$864.45	$303.83
54409	T	Revise penis prosthesis	537	28.72	$1,519.13	$864.45	$303.83
54420	T	Revision of penis	537	28.72	$1,519.13	$864.45	$303.83
54430	C	Revision of penis	.....	.....	.....	.....	.....
54435	T	Revision of penis	537	28.72	$1,519.13	$864.45	$303.83
54440	T	Repair of penis	537	28.72	$1,519.13	$864.45	$303.83
54450	T	Preputial stretching	530	2.52	$133.21	$54.69	$26.64
54500	T	Biopsy of testis	122	4.87	$257.6	$115.03	$51.52
54505	T	Biopsy of testis	546	17.15	$906.97	$453.81	$181.39
54510	T	Removal of testis lesion	546	17.15	$906.97	$453.81	$181.39
54520	T	Removal of testis	546	17.15	$906.97	$453.81	$181.39

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
54530	T	Removal of testis	546	17.15	$906.97	$453.81	$181.39
54535	C	Extensive testis surgery	.....	.....	.....	.....	.....
54550	T	Exploration for testis	546	17.15	$906.97	$453.81	$181.39
54560	C	Exploration for testis	.....	.....	.....	.....	.....
54600	T	Reduce testis torsion	546	17.15	$906.97	$453.81	$181.39
54620	T	Suspension of testis	546	17.15	$906.97	$453.81	$181.39
54640	T	Suspension of testis	546	17.15	$906.97	$453.81	$181.39
54650	C	Orchiopexy (Fowler-Stephens)	.....	.....	.....	.....	.....
54660	T	Revision of testis	546	17.15	$906.97	$453.81	$181.39
54670	T	Repair testis injury	546	17.15	$906.97	$453.81	$181.39
54680	T	Relocation of testis(es)	546	17.15	$906.97	$453.81	$181.39
54700	T	Drainage of scrotum	546	17.15	$906.97	$453.81	$181.39
54800	T	Biopsy of epididymis	122	4.87	$257.6	$115.03	$51.52
54820	T	Exploration of epididymis	546	17.15	$906.97	$453.81	$181.39
54830	T	Remove epididymis lesion	546	17.15	$906.97	$453.81	$181.39
54840	T	Remove epididymis lesion	546	17.15	$906.97	$453.81	$181.39
54860	T	Removal of epididymis	546	17.15	$906.97	$453.81	$181.39
54861	T	Removal of epididymis	546	17.15	$906.97	$453.81	$181.39
54900	T	Fusion of spermatic ducts	546	17.15	$906.97	$453.81	$181.39
54901	T	Fusion of spermatic ducts	546	17.15	$906.97	$453.81	$181.39
55000	T	Drainage of hydrocele	121	0.67	$35.26	$21.02	$7.05
55040	T	Removal of hydrocele	466	21.43	$1,133.23	$562.97	$226.65
55041	T	Removal of hydroceles	466	21.43	$1,133.23	$562.97	$226.65
55060	T	Repair of hydrocele	546	17.15	$906.97	$453.81	$181.39
55100	T	Drainage of scrotum abscess	132	6.04	$319.3	$134.24	$63.86
55110	T	Explore scrotum	546	17.15	$906.97	$453.81	$181.39
55120	T	Removal of scrotum lesion	546	17.15	$906.97	$453.81	$181.39
55150	T	Removal of scrotum	546	17.15	$906.97	$453.81	$181.39
55175	T	Revision of scrotum	546	17.15	$906.97	$453.81	$181.39
55180	T	Revision of scrotum	546	17.15	$906.97	$453.81	$181.39
55200	T	Incision of sperm duct	546	17.15	$906.97	$453.81	$181.39
55250	T	Removal of sperm duct(s)	546	17.15	$906.97	$453.81	$181.39
55300	T	Preparation,sperm duct x-ray	347	2.93	$154.75	$62.15	$30.95
55400	T	Repair of sperm duct	546	17.15	$906.97	$453.81	$181.39
55450	T	Ligation of sperm duct	546	17.15	$906.97	$453.81	$181.39
55500	T	Removal of hydrocele	546	17.15	$906.97	$453.81	$181.39
55520	T	Removal of sperm cord lesion	546	17.15	$906.97	$453.81	$181.39
55530	T	Revise spermatic cord veins	546	17.15	$906.97	$453.81	$181.39
55535	T	Revise spermatic cord veins	546	17.15	$906.97	$453.81	$181.39
55540	T	Revise hernia & sperm veins	546	17.15	$906.97	$453.81	$181.39
55600	C	Incise sperm duct pouch	.....	.....	.....	.....	.....
55605	C	Incise sperm duct pouch	.....	.....	.....	.....	.....
55650	C	Remove sperm duct pouch	.....	.....	.....	.....	.....
55680	T	Remove sperm pouch lesion	546	17.15	$906.97	$453.81	$181.39
55700	T	Biopsy of prostate	547	4.39	$232.13	$125.2	$46.43
55705	T	Biopsy of prostate	547	4.39	$232.13	$125.2	$46.43
55720	T	Drainage of prostate abscess	523	16.87	$892.28	$447.03	$178.46
55725	T	Drainage of prostate abscess	523	16.87	$892.28	$447.03	$178.46
55801	C	Removal of prostate	.....	.....	.....	.....	.....
55810	C	Extensive prostate surgery	.....	.....	.....	.....	.....
55812	C	Extensive prostate surgery	.....	.....	.....	.....	.....
55815	C	Extensive prostate surgery	.....	.....	.....	.....	.....
55821	C	Removal of prostate	.....	.....	.....	.....	.....
55831	C	Removal of prostate	.....	.....	.....	.....	.....
55840	C	Extensive prostate surgery	.....	.....	.....	.....	.....
55842	C	Extensive prostate surgery	.....	.....	.....	.....	.....
55845	C	Extensive prostate surgery	.....	.....	.....	.....	.....
55859	T	Percut/needle insert, pros	523	16.87	$892.28	$447.03	$178.46
55860	C	Surgical exposure, prostate	.....	.....	.....	.....	.....
55862	C	Extensive prostate surgery	.....	.....	.....	.....	.....
55865	C	Extensive prostate surgery	.....	.....	.....	.....	.....
55870	T	Electroejaculation	568	2.50	$132.23	$49.49	$26.45
55899	T	Genital surgery procedure	530	2.52	$133.21	$54.69	$26.64
55970	E	Sex transformation, M to F	.....	.....	.....	.....	.....
55980	E	Sex transformation, F to M	.....	.....	.....	.....	.....
56300	T	Laparoscopy; diagnostic	551	24.78	$1,310.51	$711.67	$262.1
56301	T	Laparoscopy; tubal cautery	551	24.78	$1,310.51	$711.67	$262.1
56302	T	Laparoscopy; tubal block	551	24.78	$1,310.51	$711.67	$262.1
56303	T	Laparoscopy; excise lesions	551	24.78	$1,310.51	$711.67	$262.1
56304	T	Laparoscopy; lysis	551	24.78	$1,310.51	$711.67	$262.1
56305	T	Laparoscopy; biopsy	551	24.78	$1,310.51	$711.67	$262.1
56306	T	Laparoscopy; aspiration	551	24.78	$1,310.51	$711.67	$262.1
56307	T	Laparoscopy; remove adnexa	552	37.72	$1,995.15	$1,053.16	$399.03
56308	C	Laparoscopy; hysterectomy	.....	.....	.....	.....	.....
56309	T	Laparoscopy; remove myoma	552	37.72	$1,995.15	$1,053.16	$399.03

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
56310	C	Laparoscopic enterolysis	.....	.....	.....	.....	.....
56311	T	Laparoscopic lymph node biop	552	37.72	$1,995.15	$1,053.16	$399.03
56312	T	Laparoscopic lymphadenectomy	552	37.72	$1,995.15	$1,053.16	$399.03
56313	T	Laparoscopic lymphadenectomy	552	37.72	$1,995.15	$1,053.16	$399.03
56314	C	Lapar; drain lymphocele	.....	.....	.....	.....	.....
56315	C	Laparoscopic appendectomy	.....	.....	.....	.....	.....
56316	T	Laparoscopic hernia repair	552	37.72	$1,995.15	$1,053.16	$399.03
56317	T	Laparoscopic hernia repair	552	37.72	$1,995.15	$1,053.16	$399.03
56318	T	Laparoscopic orchiectomy	552	37.72	$1,995.15	$1,053.16	$399.03
56320	T	Laparoscopy, spermatic veins	552	37.72	$1,995.15	$1,053.16	$399.03
56322	C	Laparoscopy, vagus nerves	.....	.....	.....	.....	.....
56323	C	Laparoscopy, vagus nerves	.....	.....	.....	.....	.....
56324	C	Laparoscopy, cholecystoenter	.....	.....	.....	.....	.....
56340	C	Laparoscopic cholecystectomy	.....	.....	.....	.....	.....
56341	C	Laparoscopic cholecystectomy	.....	.....	.....	.....	.....
56342	C	Laparoscopic cholecystectomy	.....	.....	.....	.....	.....
56343	T	Laparoscopic salpingostomy	552	37.72	$1,995.15	$1,053.16	$399.03
56344	T	Laparoscopic fimbrioplasty	552	37.72	$1,995.15	$1,053.16	$399.03
56345	C	Laparoscopic splenectomy	.....	.....	.....	.....	.....
56346	T	Laparoscopic gastrostomy	551	24.78	$1,310.51	$711.67	$262.1
56347	C	Laparoscopic jejunostomy	.....	.....	.....	.....	.....
56348	C	Laparo; resect intestine	.....	.....	.....	.....	.....
56349	C	Laparoscopy; fundoplasty	.....	.....	.....	.....	.....
56350	T	Hysteroscopy; diagnostic	562	12.76	$674.84	$330.86	$134.97
56351	T	Hysteroscopy; biopsy	550	16.89	$893.26	$447.93	$178.65
56352	T	Hysteroscopy; lysis	550	16.89	$893.26	$447.93	$178.65
56353	T	Hysteroscopy; resect septum	550	16.89	$893.26	$447.93	$178.65
56354	T	Hysteroscopy; remove myoma	550	16.89	$893.26	$447.93	$178.65
56355	T	Hysteroscopy; remove impact	550	16.89	$893.26	$447.93	$178.65
56356	T	Hysteroscopy; ablation	550	16.89	$893.26	$447.93	$178.65
56362	T	Laparoscopy w/cholangio	552	37.72	$1,995.15	$1,053.16	$399.03
56363	T	Laparoscopy w/biopsy	552	37.72	$1,995.15	$1,053.16	$399.03
56399	T	Laparoscopy procedure	562	12.76	$674.84	$330.86	$134.97
56405	T	I & D of vulva/perineum	561	1.52	$80.32	$24.63	$16.06
56420	T	Drainage of gland abscess	561	1.52	$80.32	$24.63	$16.06
56440	T	Surgery for vulva lesion	562	12.76	$674.84	$330.86	$134.97
56441	T	Lysis of labial lesion(s)	561	1.52	$80.32	$24.63	$16.06
56501	T	Destruction, vulva lesion(s)	152	10.43	$551.43	$261.71	$110.29
56515	T	Destruction, vulva lesion(s)	152	10.43	$551.43	$261.71	$110.29
56605	T	Biopsy of vulva/perineum	161	3.50	$385.12	$75.48	$37.02
56606	T	Biopsy of vulva/perineum	161	3.50	$185.12	$75.48	$37.02
56620	T	Partial removal of vulva	563	16.91	$894.24	$464.88	$178.85
56625	T	Complete removal of vulva	563	16.91	$894.24	$464.88	$178.85
56630	C	Extensive vulva surgery	.....	.....	.....	.....	.....
56631	C	Extensive vulva surgery	.....	.....	.....	.....	.....
56632	C	Extensive vulva surgery	.....	.....	.....	.....	.....
56633	C	Extensive vulva surgery	.....	.....	.....	.....	.....
56634	C	Extensive vulva surgery	.....	.....	.....	.....	.....
56637	C	Extensive vulva surgery	.....	.....	.....	.....	.....
56640	C	Extensive vulva surgery	.....	.....	.....	.....	.....
56700	T	Partial removal of hymen	562	12.76	$674.84	$330.86	$134.97
56720	T	Incision of hymen	562	12.76	$674.84	$330.86	$134.97
56740	T	Remove vagina gland lesion	562	12.76	$674.84	$330.86	$134.97
56800	T	Repair of vagina	562	12.76	$674.84	$330.86	$134.97
56805	C	Repair clitoris	.....	.....	.....	.....	.....
56810	T	Repair of perineum	562	12.76	$674.84	$330.86	$134.97
57000	T	Exploration of vagina	562	12.76	$674.84	$330.86	$134.97
57010	T	Drainage of pelvic abscess	562	12.76	$674.84	$330.86	$134.97
57020	T	Drainage of pelvic fluid	562	12.76	$674.84	$330.86	$134.97
57061	T	Destruction vagina lesion(s)	561	1.52	$80.32	$24.63	$16.06
57065	T	Destruction vagina lesion(s)	562	12.76	$674.84	$330.86	$134.97
57100	T	Biopsy of vagina	561	1.52	$80.32	$24.63	$16.06
57105	T	Biopsy of vagina	562	12.76	$674.84	$330.86	$134.97
57108	C	Partial removal of vagina	.....	.....	.....	.....	.....
57110	C	Removal of vagina	.....	.....	.....	.....	.....
57120	C	Closure of vagina	.....	.....	.....	.....	.....
57130	T	Remove vagina lesion	562	12.76	$674.84	$330.86	$134.97
57135	T	Remove vagina lesion	562	12.76	$674.84	$330.86	$134.97
57150	T	Treat vagina infection	561	1.52	$80.32	$24.63	$16.06
57160	T	Insertion of pessary/device	561	1.52	$80.32	$24.63	$16.06
57170	T	Fitting of diaphragm/cap	561	1.52	$80.32	$24.63	$16.06
57180	T	Treat vaginal bleeding	561	1.52	$80.32	$24.63	$16.06
57200	T	Repair of vagina	562	12.76	$674.84	$330.86	$134.97
57210	T	Repair vagina/perineum	562	12.76	$674.84	$330.86	$134.97
57220	T	Revision of urethra	563	16.91	$894.24	$464.88	$178.85

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
57230	T	Repair of urethral lesion	562	12.76	$674.84	$330.86	$134.97
57240	T	Repair bladder & vagina	563	16.91	$894.24	$464.88	$178.85
57250	T	Repair rectum & vagina	563	16.91	$894.24	$464.88	$178.85
57260	T	Repair of vagina	563	16.91	$894.24	$464.88	$178.85
57265	T	Extensive repair of vagina	563	16.91	$894.24	$464.88	$178.85
57268	T	Repair of bowel bulge	563	16.91	$894.24	$464.88	$178.85
57270	C	Repair of bowel pouch					
57280	C	Suspension of vagina					
57282	C	Repair of vaginal prolapse					
57284	T	Repair paravaginal defect	563	16.91	$894.24	$464.88	$178.85
57288	T	Repair bladder defect	563	16.91	$894.24	$464.88	$178.85
57289	T	Repair bladder & vagina	563	16.91	$894.24	$464.88	$178.85
57291	T	Construction of vagina	563	16.91	$894.24	$464.88	$178.85
57292	C	Construct vagina with graft					
57300	T	Repair rectum-vagina fistula	563	16.91	$894.24	$464.88	$178.85
57305	C	Repair rectum-vagina fistula					
57307	C	Fistula repair & colostomy					
57308	C	Fistula repair, transperine					
57310	C	Repair urethrovaginal lesion					
57311	C	Repair urethrovaginal lesion					
57320	C	Repair bladder-vagina lesion					
57330	C	Repair bladder-vagina lesion					
57335	C	Repair vagina					
57400	T	Dilation of vagina	562	12.76	$674.84	$330.86	$134.97
57410	T	Pelvic examination	562	12.76	$674.84	$330.86	$134.97
57415	T	Removal vaginal foreign body	562	12.76	$674.84	$330.86	$134.97
57452	T	Examination of vagina	561	1.52	$80.32	$24.63	$16.06
57454	T	Vagina examination & biopsy	561	1.52	$80.32	$24.63	$16.06
57460	T	Cervix excision	562	12.76	$674.84	$330.86	$134.97
57500	T	Biopsy of cervix	561	1.52	$80.32	$24.63	$16.06
57505	T	Endocervical curettage	561	1.52	$80.32	$24.63	$16.06
57510	T	Cauterization of cervix	561	1.52	$80.32	$24.63	$16.06
57511	T	Cryocautery of cervix	561	1.52	$80.32	$24.63	$16.06
57513	T	Laser surgery of cervix	561	1.52	$80.32	$24.63	$16.06
57520	T	Conization of cervix	563	16.91	$894.24	$464.88	$178.85
57522	T	Conization of cervix	563	16.91	$894.24	$464.88	$178.85
57530	T	Removal of cervix	563	16.91	$894.24	$464.88	$178.85
57531	C	Removal of cervix, radical					
57540	C	Removal of residual cervix					
57545	C	Remove cervix, repair pelvis					
57550	T	Removal of residual cervix	563	16.91	$894.24	$464.88	$178.85
57555	T	Remove cervix, repair vagina	563	16.91	$894.24	$464.88	$178.85
57556	T	Remove cervix, repair bowel	563	16.91	$894.24	$464.88	$178.85
57700	T	Revision of cervix	562	12.76	$674.84	$330.86	$134.97
57720	T	Revision of cervix	562	12.76	$674.84	$330.86	$134.97
57800	T	Dilation of cervical canal	561	1.52	$80.32	$24.63	$16.06
57820	T	D&c of residual cervix	567	13.61	$719.9	$364.09	$143.98
58100	T	Biopsy of uterus lining	561	1.52	$80.32	$24.63	$16.06
58120	T	Dilation and curettage (D&C)	567	13.61	$719.9	$364.09	$143.98
58140	C	Removal of uterus lesion					
58145	T	Removal of uterus lesion	563	16.91	$894.24	$464.88	$178.85
58150	C	Total hysterectomy					
58152	C	Total hysterectomy					
58180	C	Partial hysterectomy					
58200	C	Extensive hysterectomy					
58210	C	Extensive hysterectomy					
58240	C	Removal of pelvis contents					
58260	C	Vaginal hysterectomy					
58262	C	Vaginal hysterectomy					
58263	C	Vaginal hysterectomy					
58267	C	Hysterectomy & vagina repair					
58270	C	Hysterectomy & vagina repair					
58275	C	Hysterectomy, revise vagina					
58280	C	Hysterectomy, revise vagina					
58285	C	Extensive hysterectomy					
58300	E	Insert intrauterine device					
58301	T	Remove intrauterine device	561	1.52	$80.32	$24.63	$16.06
58321	T	Artificial insemination	568	2.50	$132.23	$49.49	$26.45
58322	T	Artificial insemination	568	2.50	$132.23	$49.49	$26.45
58323	T	Sperm washing	568	2.50	$132.23	$49.49	$26.45
58340	T	Catheter for hysterography	347	2.93	$154.75	$62.15	$30.95
58345	T	Reopen fallopian tube	562	12.76	$674.84	$330.86	$134.97
58350	T	Reopen fallopian tube	562	12.76	$674.84	$330.86	$134.97
58400	C	Suspension of uterus					
58410	C	Suspension of uterus					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
58520	C	Repair of ruptured uterus					
58540	C	Revision of uterus					
58600	C	Division of fallopian tube					
58605	C	Division of fallopian tube					
58611	C	Ligate oviduct(s)					
58615	C	Occlude fallopian tube(s)					
58700	C	Removal of fallopian tube					
58720	C	Removal of ovary/tube(s)					
58740	C	Revise fallopian tube(s)					
58750	C	Repair oviduct					
58752	C	Revise ovarian tube(s)					
58760	C	Remove tubal obstruction					
58770	C	Create new tubal opening					
58800	T	Drainage of ovarian cyst(s)	563	16.91	$894.24	$464.88	$178.85
58805	C	Drainage of ovarian cyst(s)					
58820	T	Open drain ovary abscess	563	16.91	$894.24	$464.88	$178.85
58822	C	Percut drain ovary abscess					
58823	C	Percut drain pelvic abscess					
58825	C	Transposition, ovary(s)					
58900	C	Biopsy of ovary(s)					
58920	C	Partial removal of ovary(s)					
58925	C	Removal of ovarian cyst(s)					
58940	C	Removal of ovary(s)					
58943	C	Removal of ovary(s)					
58950	C	Resect ovarian malignancy					
58951	C	Resect ovarian malignancy					
58952	C	Resect ovarian malignancy					
58960	C	Exploration of abdomen					
58970	T	Retrieval of oocyte	562	12.76	$674.84	$330.86	$134.97
58974	T	Transfer of embryo	568	2.50	$132.23	$49.49	$26.45
58976	T	Transfer of embryo	568	2.50	$132.23	$49.49	$26.45
58999	T	Genital surgery procedure	161	3.50	$185.12	$75.48	$37.02
59000	T	Amniocentesis	578	1.26	$66.60	$33.90	$13.32
59012	T	Fetal cord puncture, prenatal	578	1.26	$66.60	$33.90	$13.32
59015	T	Chorion biopsy	578	1.26	$66.60	$33.90	$13.32
59020	T	Fetal contract stress test	578	1.26	$66.60	$33.90	$13.32
59025	T	Fetal non-stress test	578	1.26	$66.60	$33.90	$13.32
59030	T	Fetal scalp blood sample	578	1.26	$66.60	$33.90	$13.32
59050	T	Fetal monitor w/report	578	1.26	$66.60	$33.90	$13.32
59051	N	Fetal monitor/interpret only					
59100	C	Remove uterus lesion					
59120	C	Treat ectopic pregnancy					
59121	C	Treat ectopic pregnancy					
59130	C	Treat ectopic pregnancy					
59135	C	Treat ectopic pregnancy					
59136	C	Treat ectopic pregnancy					
59140	C	Treat ectopic pregnancy					
59150	C	Treat ectopic pregnancy					
59151	C	Treat ectopic pregnancy					
59160	T	D&C after delivery	567	13.61	$719.90	$364.09	$143.98
59200	T	Insert cervical dilator	561	1.52	$80.32	$24.63	$16.06
59300	T	Episiotomy or vaginal repair	562	12.76	$674.84	$330.86	$134.97
59320	T	Revision of cervix	562	12.76	$674.84	$330.86	$134.97
59325	C	Revision of cervix					
59350	C	Repair of uterus					
59400	E	Obstetrical care					
59409	T	Obstetrical care	580	4.59	$242.90	$146.45	$48.58
59410	E	Obstetrical care					
59412	T	Antepartum manipulation	580	4.59	$242.90	$146.45	$48.58
59414	T	Deliver placenta	580	4.59	$242.90	$146.45	$48.58
59425	E	Antepartum care only					
59426	E	Antepartum care only					
59430	E	Care after delivery					
59510	E	Cesarean delivery					
59514	C	Cesarean delivery only					
59515	E	Cesarean delivery					
59525	C	Remove uterus after cesarean					
59610	E	Vbac delivery					
59612	T	Vbac delivery only	580	4.59	$242.90	$146.45	$48.58
59614	E	Vbac care after delivery					
59618	E	Attempted vbac delivery					
59620	C	Attempted vbac delivery only					
59622	E	Attempted vbac after care					
59812	T	Treatment of miscarriage	587	13.26	$701.29	$347.14	$140.26
59820	T	Care of miscarriage	587	13.26	$701.29	$347.14	$140.26

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
59821	T	Treatment of miscarriage	587	13.26	$701.29	$347.14	$140.26
59830	C	Treat uterus infection					
59840	T	Abortion	586	12.50	$661.13	$431.89	$132.23
59841	T	Abortion	586	12.50	$661.13	$431.89	$132.23
59850	C	Abortion					
59851	C	Abortion					
59852	C	Abortion					
59855	C	Abortion					
59856	C	Abortion					
59857	C	Abortion					
59866	C	Abortion					
59870	T	Evacuate mole of uterus	587	13.26	$701.29	$347.14	$140.26
59871	T	Remove cerclage suture	562	12.76	$674.84	$330.86	$134.97
59899	T	Maternity care procedure	578	1.26	$66.60	$33.90	$13.32
60000	T	Drain thyroid/tongue cyst	312	7.26	$383.95	$178.31	$76.79
60001	T	Aspirate/inject thyroid cyst	121	0.67	$35.26	$21.02	$7.05
60100	T	Biopsy of thyroid	122	4.87	$257.60	$115.03	$51.52
60200	T	Remove thyroid lesion	397	18.37	$971.62	$496.97	$194.32
60210	T	Partial excision thyroid	397	18.37	$971.62	$496.97	$194.32
60212	C	Partial thyroid excision					
60220	T	Partial removal of thyroid	397	18.37	$971.62	$496.97	$194.32
60225	T	Partial removal of thyroid	397	18.37	$971.62	$496.97	$194.32
60240	T	Removal of thyroid	397	18.37	$971.62	$496.97	$194.32
60252	C	Removal of thyroid					
60254	C	Extensive thyroid surgery					
60260	C	Repeat thyroid surgery					
60270	C	Removal of thyroid					
60271	C	Removal of thyroid					
60280	T	Remove thyroid duct lesion	397	18.37	$971.62	$496.97	$194.32
60281	T	Remove thyroid duct lesion	397	18.37	$971.62	$496.97	$194.32
60500	C	Explore parathyroid glands					
60502	C	Re-explore parathyroids					
60505	C	Explore parathyroid glands					
60512	C	Autotransplant, parathyroid					
60520	C	Removal of thymus gland					
60521	C	Removal thymus gland					
60522	C	Removal of thymus gland					
60540	C	Explore adrenal gland					
60545	C	Explore adrenal gland					
60600	C	Remove carotid body lesion					
60605	C	Remove carotid body lesion					
60699	T	Endocrine surgery procedure	121	0.67	$35.26	$21.02	$7.05
61000	T	Remove cranial cavity fluid	602	3.33	$176.30	$87.69	$35.26
61001	T	Remove cranial cavity fluid	602	3.33	$176.30	$87.69	$35.26
61020	T	Remove brain cavity fluid	602	3.33	$176.30	$87.69	$35.26
61026	T	Injection into brain canal	602	3.33	$176.30	$87.69	$35.26
61050	T	Remove brain canal fluid	602	3.33	$176.30	$87.69	$35.26
61055	T	Injection into brain canal	602	3.33	$176.30	$87.69	$35.26
61070	T	Brain canal shunt procedure	602	3.33	$176.30	$87.69	$35.26
61105	C	Drill skull for examination					
61106	C	Drill skull for exam/surgery					
61107	C	Drill skull for implantation					
61108	C	Drill skull for drainage					
61120	C	Pierce skull for examination					
61130	C	Pierce skull, exam/surgery					
61140	C	Pierce skull for biopsy					
61150	C	Pierce skull for drainage					
61151	C	Pierce skull for drainage					
61154	C	Pierce skull, remove clot					
61156	C	Pierce skull for drainage					
61210	C	Pierce skull; implant device					
61215	T	Insert brain-fluid device	618	25.56	$1,351.64	$780.60	$270.33
61250	C	Pierce skull & explore					
61253	C	Pierce skull & explore					
61304	C	Open skull for exploration					
61305	C	Open skull for exploration					
61312	C	Open skull for drainage					
61313	C	Open skull for drainage					
61314	C	Open skull for drainage					
61315	C	Open skull for drainage					
61320	C	Open skull for drainage					
61321	C	Open skull for drainage					
61330	C	Decompress eye socket					
61332	C	Explore/biopsy eye socket					
61333	C	Explore orbit; remove lesion					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
61334	C	Explore orbit; remove object					
61340	C	Relieve cranial pressure					
61343	C	Incise skull, pressure relief					
61345	C	Relieve cranial pressure					
61440	C	Incise skull for surgery					
61450	C	Incise skull for surgery					
61458	C	Incise skull for brain wound					
61460	C	Incise skull for surgery					
61470	C	Incise skull for surgery					
61480	C	Incise skull for surgery					
61490	C	Incise skull for surgery					
61500	C	Removal of skull lesion					
61501	C	Remove infected skull bone					
61510	C	Removal of brain lesion					
61512	C	Remove brain lining lesion					
61514	C	Removal of brain abscess					
61516	C	Removal of brain lesion					
61518	C	Removal of brain lesion					
61519	C	Remove brain lining lesion					
61520	C	Removal of brain lesion					
61521	C	Removal of brain lesion					
61522	C	Removal of brain abscess					
61524	C	Removal of brain lesion					
61526	C	Removal of brain lesion					
61530	C	Removal of brain lesion					
61531	C	Implant brain electrodes					
61533	C	Implant brain electrodes					
61534	C	Removal of brain lesion					
61535	C	Remove brain electrodes					
61536	C	Removal of brain lesion					
61538	C	Removal of brain tissue					
61539	C	Removal of brain tissue					
61541	C	Incision of brain tissue					
61542	C	Removal of brain tissue					
61543	C	Removal of brain tissue					
61544	C	Remove and treat brain lesion					
61545	C	Excision of brain tumor					
61546	C	Removal of pituitary gland					
61548	C	Removal of pituitary gland					
61550	C	Release of skull seams					
61552	C	Release of skull seams					
61556	C	Incise skull/sutures					
61557	C	Incise skull/sutures					
61558	C	Excision of skull/sutures					
61559	C	Excision of skull/sutures					
61563	C	Excision of skull tumor					
61564	C	Excision of skull tumor					
61570	C	Remove brain foreign body					
61571	C	Incise skull for brain wound					
61575	C	Skull base/brainstem surgery					
61576	C	Skull base/brainstem surgery					
61580	C	Craniofacial approach, skull					
61581	C	Craniofacial approach, skull					
61582	C	Craniofacial approach, skull					
61583	C	Craniofacial approach, skull					
61584	C	Orbitocranial approach/skull					
61585	C	Orbitocranial approach/skull					
61586	C	Resect nasopharynx, skull					
61590	C	Infratemporal approach/skull					
61591	C	Infratemporal approach/skull					
61592	C	Orbitocranial approach/skull					
61595	C	Transtemporal approach/skull					
61596	C	Transcochlear approach/skull					
61597	C	Transcondylar approach/skull					
61598	C	Transpetrosal approach/skull					
61600	C	Resect/excise cranial lesion					
61601	C	Resect/excise cranial lesion					
61605	C	Resect/excise cranial lesion					
61606	C	Resect/excise cranial lesion					
61607	C	Resect/excise cranial lesion					
61608	C	Resect/excise cranial lesion					
61609	C	Transect, artery, sinus					
61610	C	Transect, artery, sinus					
61611	C	Transect, artery, sinus					
61612	C	Transect, artery, sinus					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
61613	C	Remove aneurysm, sinus					
61615	C	Resect/excise lesion, skull					
61616	C	Resect/excise lesion, skull					
61618	C	Repair dura					
61619	C	Repair dura					
61624	C	Occlusion/embolization cath					
61626	C	Occlusion/embolization cath					
61680	C	Intracranial vessel surgery					
61682	C	Intracranial vessel surgery					
61684	C	Intracranial vessel surgery					
61686	C	Intracranial vessel surgery					
61690	C	Intracranial vessel surgery					
61692	C	Intracranial vessel surgery					
61700	C	Inner skull vessel surgery					
61702	C	Inner skull vessel surgery					
61703	C	Clamp neck artery					
61705	C	Revise circulation to head					
61708	C	Revise circulation to head					
61710	C	Revise circulation to head					
61711	C	Fusion of skull arteries					
61712	C	Skull or spine microsurgery					
61720	C	Incise skull/brain surgery					
61735	C	Incise skull/brain surgery					
61750	C	Incise skull; brain biopsy					
61751	C	Brain biopsy with cat scan					
61760	C	Implant brain electrodes					
61770	C	Incise skull for treatment					
61790	T	Treat trigeminal nerve	631	12.98	$686.60	$333.80	$137.32
61791	C	Treat trigeminal tract					
61793	S	Focus radiation beam	757	2.20	$116.55	$52.43	$23.31
61795	C	Brain surgery using computer					
61850	C	Implant neuroelectrodes					
61855	C	Implant neuroelectrodes					
61860	C	Implant neuroelectrodes					
61865	C	Implant neuroelectrodes					
61870	C	Implant neuroelectrodes					
61875	C	Implant neuroelectrodes					
61880	C	Revise/remove neuroelectrode					
61885	T	Implant neuroreceiver	618	25.56	$1,351.64	$780.60	$270.33
61888	C	Revise/remove neuroreceiver					
62000	C	Repair of skull fracture					
62005	C	Repair of skull fracture					
62010	C	Treatment of head injury					
62100	C	Repair brain fluid leakage					
62115	C	Reduction of skull defect					
62116	C	Reduction of skull defect					
62117	C	Reduction of skull defect					
62120	C	Repair skull cavity lesion					
62121	C	Incise skull repair					
62140	C	Repair of skull defect					
62141	C	Repair of skull defect					
62142	C	Remove skull plate/flap					
62143	C	Replace skull plate/flap					
62145	C	Repair of skull and brain					
62146	C	Repair of skull with graft					
62147	C	Repair of skull with graft					
62180	C	Establish brain cavity shunt					
62190	C	Establish brain cavity shunt					
62192	C	Establish brain cavity shunt					
62194	T	Replace/irrigate catheter	602	3.33	$176.30	$87.69	$35.26
62200	C	Establish brain cavity shunt					
62201	C	Establish brain cavity shunt					
62220	C	Establish brain cavity shunt					
62223	C	Establish brain cavity shunt					
62225	T	Replace/irrigate catheter	602	3.33	$176.30	$87.69	$35.26
62230	T	Replace/revise brain shunt	617	11.56	$611.18	$287.70	$122.24
62256	C	Remove brain cavity shunt					
62258	C	Replace brain cavity shunt					
62268	T	Drain spinal cord cyst	602	3.33	$176.30	$87.69	$35.26
62269	T	Needle biopsy spinal cord	122	4.87	$257.60	$115.03	$51.52
62270	T	Spinal fluid tap, diagnostic	600	2.63	$139.08	$61.47	$27.82
62272	T	Drain spinal fluid	600	2.63	$139.08	$61.47	$27.82
62273	T	Treat lumbar spine lesion	602	3.33	$176.30	$87.69	$35.26
62274	T	Inject spinal anesthetic	602	3.33	$176.30	$87.69	$35.26
62275	T	Inject spinal anesthetic	602	3.33	$176.30	$87.69	$35.26

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
62276	T	Inject spinal anesthetic	602	3.33	$176.30	$87.69	$35.26
62277	T	Inject spinal anesthetic	602	3.33	176.30	$87.69	$35.26
62278	T	Inject spinal anesthetic	602	3.33	$176.30	$87.69	$35.26
62279	T	Inject spinal anesthetic	602	3.33	$176.30	$87.69	$35.26
62280	T	Treat spinal cord lesion	602	3.33	$176.30	$87.69	$35.26
62281	T	Treat spinal cord lesion	602	3.33	$176.30	$87.69	$35.26
62282	T	Treat spinal canal lesion	602	3.33	$176.30	$87.69	$35.26
62284	T	Injection for myelogram	347	2.93	$154.75	$62.15	$30.95
62287	T	Percutaneous diskectomy	631	12.98	$686.60	$333.80	$137.32
62288	T	Injection into spinal canal	602	3.33	$176.30	$87.69	$35.26
62289	T	Injection into spinal canal	602	3.33	$176.30	$87.69	$35.26
62290	T	Inject for spine disk x-ray	347	2.93	$154.75	$62.15	$30.95
62291	T	Inject for spine disk x-ray	347	2.93	$154.75	$62.15	$30.95
62292	T	Injection into disk lesion	602	3.33	$176.30	$87.69	$35.26
62294	T	Injection into spinal artery	602	3.33	$176.30	$87.69	$35.26
62298	T	Injection into spinal canal	602	3.33	$176.30	$87.69	$35.26
62350	T	Implant spinal catheter	617	11.56	$611.18	$287.70	$122.24
62351	C	Implant spinal catheter					
62355	T	Remove spinal canal catheter	617	11.56	$611.18	$287.70	$122.24
62360	T	Insert spine infusion device	618	25.56	$1,351.64	$780.60	$270.33
62361	T	Implant spine infusion pump	618	25.56	$1,351.64	$780.60	$270.33
62362	T	Implant spine infusion pump	618	25.56	$1,351.64	$780.60	$270.33
62365	T	Remove spine infusion device	617	11.56	$611.18	$287.70	$122.24
62367	X	Analyze spine infusion pump	966	0.39	$20.57	$12.43	$4.11
62368	X	Analyze spine infusion pump	966	0.39	$20.57	$12.43	$4.11
63001	C	Removal of spinal lamina					
63003	C	Removal of spinal lamina					
63005	C	Removal of spinal lamina					
63011	C	Removal of spinal lamina					
63012	C	Removal of spinal lamina					
63015	C	Removal of spinal lamina					
63016	C	Removal of spinal lamina					
63017	C	Removal of spinal lamina					
63020	C	Neck spine disk surgery					
63030	C	Low back disk surgery					
63035	C	Added spinal disk surgery					
63040	C	Neck spine disk surgery					
63042	C	Low back disk surgery					
63045	C	Removal of spinal lamina					
63046	C	Removal of spinal lamina					
63047	C	Removal of spinal lamina					
63048	C	Removal of spinal lamina					
63055	C	Decompress spinal cord					
63056	C	Decompress spinal cord					
63057	C	Decompress spinal cord					
63064	C	Decompress spinal cord					
63066	C	Decompress spinal cord					
63075	C	Neck spine disk surgery					
63076	C	Neck spine disk surgery					
63077	C	Spine disk surgery, thorax					
63078	C	Spine disk surgery, thorax					
63081	C	Removal of vertebral body					
63082	C	Removal of vertebral body					
63085	C	Removal of vertebral body					
63086	C	Removal of vertebral body					
63087	C	Removal of vertebral body					
63088	C	Removal of vertebral body					
63090	C	Removal of vertebral body					
63091	C	Removal of vertebral body					
63170	C	Incise spinal cord tract(s)					
63172	C	Drainage of spinal cyst					
63173	C	Drainage of spinal cyst					
63180	C	Revise spinal cord ligaments					
63182	C	Revise spinal cord ligaments					
63185	C	Incise spinal column/nerves					
63190	C	Incise spinal column/nerves					
63191	C	Incise spinal column/nerves					
63194	C	Incise spinal column & cord					
63195	C	Incise spinal column & cord					
63196	C	Incise spinal column & cord					
63197	C	Incise spinal column & cord					
63198	C	Incise spinal column & cord					
63199	C	Incise spinal column & cord					
63200	C	Release of spinal cord					
63250	C	Revise spinal cord vessels					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
63251	C	Revise spinal cord vessels					
63252	C	Revise spinal cord vessels					
63265	C	Excise intraspinal lesion					
63266	C	Excise intraspinal lesion					
63267	C	Excise intraspinal lesion					
63268	C	Excise intraspinal lesion					
63270	C	Excise intraspinal lesion					
63271	C	Excise intraspinal lesion					
63272	C	Excise intraspinal lesion					
63273	C	Excise intraspinal lesion					
63275	C	Biopsy/excise spinal tumor					
63276	C	Biopsy/excise spinal tumor					
63277	C	Biopsy/excise spinal tumor					
63278	C	Biopsy/excise spinal tumor					
63280	C	Biopsy/excise spinal tumor					
63281	C	Biopsy/excise spinal tumor					
63282	C	Biopsy/excise spinal tumor					
63283	C	Biopsy/excise spinal tumor					
63285	C	Biopsy/excise spinal tumor					
63286	C	Biopsy/excise spinal tumor					
63287	C	Biopsy/excise spinal tumor					
63290	C	Biopsy/excise spinal tumor					
63300	C	Removal of vertebral body					
63301	C	Removal of vertebral body					
63302	C	Removal of vertebral body					
63303	C	Removal of vertebral body					
63304	C	Removal of vertebral body					
63305	C	Removal of vertebral body					
63306	C	Removal of vertebral body					
63307	C	Removal of vertebral body					
63308	C	Removal of vertebral body					
63600	T	Remove spinal cord lesion	631	12.98	$686.60	$333.80	$137.32
63610	T	Stimulation of spinal cord	631	12.98	$686.60	$333.80	$137.32
63615	T	Remove lesion of spinal cord	631	12.98	$686.60	$333.80	$137.32
63650	T	Implant neuroelectrodes	616	14.43	$762.99	$366.57	$152.60
63655	C	Implant neuroelectrodes					
63660	T	Revise/remove neuroelectrode	617	11.56	$611.18	$287.70	$122.24
63685	T	Implant neuroreceiver	618	25.56	$1,351.64	$780.60	$270.33
63688	T	Revise/remove neuroreceiver	617	11.56	$611.18	$287.70	$122.24
63690	X	Analysis of neuroreceiver	966	0.39	$20.57	$12.43	$4.11
63691	X	Analysis of neuroreceiver	966	0.39	$20.57	$12.43	$4.11
63700	C	Repair of spinal herniation					
63702	C	Repair of spinal herniation					
63704	C	Repair of spinal herniation					
63706	C	Repair of spinal herniation					
63707	C	Repair spinal fluid leakage					
63709	C	Repair spinal fluid leakage					
63710	C	Graft repair of spine defect					
63740	C	Install spinal shunt					
63741	C	Install spinal shunt					
63744	T	Revision of spinal shunt	617	11.56	$611.18	$287.70	$122.24
63746	T	Removal of spinal shunt	617	11.56	$611.18	$287.70	$122.24
64400	T	Injection for nerve block	601	3.11	$164.55	$74.13	$32.91
64402	T	Injection for nerve block	601	3.11	$164.55	$74.13	$32.91
64405	T	Injection for nerve block	601	3.11	$164.55	$74.13	$32.91
64408	T	Injection for nerve block	601	3.11	$164.55	$74.13	$32.91
64410	T	Injection for nerve block	601	3.11	$164.55	$74.13	$32.91
64412	T	Injection for nerve block	601	3.11	$164.55	$74.13	$32.91
64413	T	Injection for nerve block	601	3.11	$164.55	$74.13	$32.91
64415	T	Injection for nerve block	601	3.11	$164.55	$74.13	$32.91
64417	T	Injection for nerve block	601	3.11	$164.55	$74.13	$32.91
64418	T	Injection for nerve block	601	3.11	$164.55	$74.13	$32.91
64420	T	Injection for nerve block	601	3.11	$164.55	$74.13	$32.91
64421	T	Injection for nerve block	601	3.11	$164.55	$74.13	$32.91
64425	T	Injection for nerve block	601	3.11	$164.55	$74.13	$32.91
64430	T	Injection for nerve block	601	3.11	$164.55	$74.13	$32.91
64435	T	Injection for nerve block	601	3.11	$164.55	$74.13	$32.91
64440	T	Injection for nerve block	601	3.11	$164.55	$74.13	$32.91
64441	T	Injection for nerve block	601	3.11	$164.55	$74.13	$32.91
64442	T	Injection for nerve block	601	3.11	$164.55	$74.13	$32.91
64443	T	Injection for nerve block	601	3.11	$164.55	$74.13	$32.91
64445	T	Injection for nerve block	601	3.11	$164.55	$74.13	$32.91
64450	T	Injection for nerve block	601	3.11	$164.55	$74.13	$32.91
64505	T	Injection for nerve block	601	3.11	$164.55	$74.13	$32.91
64508	T	Injection for nerve block	601	3.11	$164.55	$74.13	$32.91

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
64510	T	Injection for nerve block	601	3.11	$164.55	$74.13	$32.91
64520	T	Injection for nerve block	601	3.11	$164.55	$74.13	$32.91
64530	T	Injection for nerve block	601	3.11	$164.55	$74.13	$32.91
64550	A	Apply neurostimulator	.....	.....	.....	.....	.....
64553	T	Implant neuroelectrodes	616	14.43	$762.99	$366.57	$152.60
64555	T	Implant neuroelectrodes	616	14.43	$762.99	$366.57	$152.60
64560	T	Implant neuroelectrodes	616	14.43	$762.99	$366.57	$152.60
64565	T	Implant neuroelectrodes	616	14.43	$762.99	$366.57	$152.60
64573	T	Implant neuroelectrodes	616	14.43	$762.99	$366.57	$152.60
64575	T	Implant neuroelectrodes	616	14.43	$762.99	$366.57	$152.60
64577	T	Implant neuroelectrodes	616	14.43	$762.99	$366.57	$152.60
64580	T	Implant neuroelectrodes	616	14.43	$762.99	$366.57	$152.60
64585	T	Revise/remove neuroelectrode	617	11.56	$611.18	$287.70	$122.24
64590	T	Implant neuroreceiver	618	25.56	$1,351.64	$780.60	$270.33
64595	T	Revise/remove neuroreceiver	617	11.56	$611.18	$287.70	$122.24
64600	T	Injection treatment of nerve	601	3.11	$164.55	$74.13	$32.91
64605	T	Injection treatment of nerve	601	3.11	$164.55	$74.13	$32.91
64610	T	Injection treatment of nerve	601	3.11	$164.55	$74.13	$32.91
64612	T	Destroy nerve, face muscle	601	3.11	$164.55	$74.13	$32.91
64613	T	Destroy nerve, spine muscle	601	3.11	$164.55	$74.13	$32.91
64620	T	Injection treatment of nerve	601	3.11	$164.55	$74.13	$32.91
64622	T	Injection treatment of nerve	601	3.11	$164.55	$74.13	$32.91
64623	T	Injection treatment of nerve	601	3.11	$164.55	$74.13	$32.91
64630	T	Injection treatment of nerve	601	3.11	$164.55	$74.13	$32.91
64640	T	Injection treatment of nerve	601	3.11	$164.55	$74.13	$32.91
64680	T	Injection treatment of nerve	601	3.11	$164.55	$74.13	$32.91
64702	T	Revise finger/toe nerve	631	12.98	$686.60	$333.80	$137.32
64704	T	Revise hand/foot nerve	631	12.98	$686.60	$333.80	$137.32
64708	T	Revise arm/leg nerve	631	12.98	$686.60	$333.80	$137.32
64712	T	Revision of sciatic nerve	631	12.98	$686.60	$333.8	$137.32
64713	T	Revision of arm nerve(s)	631	12.98	$686.60	$333.80	$137.32
64714	T	Revise low back nerve(s)	631	12.98	$686.60	$333.80	$137.32
64716	T	Revision of cranial nerve	631	12.98	$686.60	$333.80	$137.32
64718	T	Revise ulnar nerve at elbow	631	12.98	$686.60	$333.80	$137.32
64719	T	Revise ulnar nerve at wrist	631	12.98	$686.60	$333.80	$137.32
64721	T	Carpal tunnel surgery	631	12.98	$686.60	$333.80	$137.32
64722	T	Relieve pressure on nerve(s)	631	12.98	$686.60	$333.80	$137.32
64726	T	Release foot/toe nerve	631	12.98	$686.60	$333.80	$137.32
64727	T	Internal nerve revision	631	12.98	$686.60	$333.80	$137.32
64732	T	Incision of brow nerve	631	12.98	$686.60	$333.80	$137.32
64734	T	Incision of cheek nerve	631	12.98	$686.60	$333.80	$137.32
64736	T	Incision of chin nerve	631	12.98	$686.60	$333.80	$137.32
64738	T	Incision of jaw nerve	631	12.98	$686.60	$333.80	$137.32
64740	T	Incision of tongue nerve	631	12.98	$686.60	$333.8	$137.32
64742	T	Incision of facial nerve	631	12.98	$686.60	$333.80	$137.32
64744	T	Incise nerve, back of head	631	12.98	$686.60	$333.80	$137.32
64746	T	Incise diaphragm nerve	631	12.98	$686.60	$333.80	$137.32
64752	C	Incision of vagus nerve	.....	.....	.....	.....	.....
64755	C	Incision of stomach nerves	.....	.....	.....	.....	.....
64760	C	Incision of vagus nerve	.....	.....	.....	.....	.....
64761	T	Incision of pelvis nerve	631	12.98	$686.60	$333.80	$137.32
64763	C	Incise hip/thigh nerve	.....	.....	.....	.....	.....
64766	C	Incise hip/thigh nerve	.....	.....	.....	.....	.....
64771	T	Sever cranial nerve	631	12.98	$686.60	$333.80	$137.32
64772	T	Incision of spinal nerve	631	12.98	$686.60	$333.80	$137.32
64774	T	Remove skin nerve lesion	631	12.98	$686.60	$333.80	$137.32
64776	T	Remove digit nerve lesion	631	12.98	$686.60	$333.80	$137.32
64778	T	Added digit nerve surgery	631	12.98	$686.60	$333.80	$137.32
64782	T	Remove limb nerve lesion	631	12.98	$686.60	$333.80	$137.32
64783	T	Added limb nerve surgery	631	12.98	$686.60	$333.80	$137.32
64784	T	Remove nerve lesion	631	12.98	$686.60	$333.80	$137.32
64786	T	Remove sciatic nerve lesion	632	18.13	$958.88	$461.04	$191.78
64787	T	Implant nerve end	631	12.98	$686.60	$333.80	$137.32
64788	T	Remove skin nerve lesion	631	12.98	$686.60	$333.80	$137.32
64790	T	Removal of nerve lesion	631	12.98	$686.60	$333.80	$137.32
64792	T	Removal of nerve lesion	632	18.13	$958.88	$461.04	$191.78
64795	T	Biopsy of nerve	631	12.98	$686.60	$333.80	$137.32
64802	C	Remove sympathetic nerves	.....	.....	.....	.....	.....
64804	C	Remove sympathetic nerves	.....	.....	.....	.....	.....
64809	C	Remove sympathetic nerves	.....	.....	.....	.....	.....
64818	C	Remove sympathetic nerves	.....	.....	.....	.....	.....
64820	C	Remove sympathetic nerves	.....	.....	.....	.....	.....
64830	T	Microrepair of nerve	631	12.98	$686.60	$333.80	$137.32
64831	T	Repair of digit nerve	632	18.13	$958.88	$461.04	$191.78
64832	T	Repair additional nerve	632	18.13	$958.88	$461.04	$191.78

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
64834	T	Repair of hand or foot nerve	632	18.13	$958.88	$461.04	$191.78
64835	T	Repair of hand or foot nerve	632	18.13	$958.88	$461.04	$191.78
64836	T	Repair of hand or foot nerve	632	18.13	$958.88	$461.04	$191.78
64837	T	Repair additional nerve	632	18.13	$958.88	$461.04	$191.78
64840	T	Repair of leg nerve	632	18.13	$958.88	$461.04	$191.78
64856	T	Repair/transpose nerve	632	18.13	$958.88	$461.04	$191.78
64857	T	Repair arm/leg nerve	632	18.13	$958.88	$461.04	$191.78
64858	T	Repair sciatic nerve	632	18.13	$958.88	$461.04	$191.78
64859	T	Additional nerve surgery	632	18.13	$958.88	$461.04	$191.78
64861	T	Repair of arm nerves	632	18.13	$958.88	$461.04	$191.78
64862	T	Repair of low back nerves	632	18.13	$958.88	$461.04	$191.78
64864	T	Repair of facial nerve	632	18.13	$958.88	$461.04	$191.78
64865	T	Repair of facial nerve	632	18.13	$958.88	$461.04	$191.78
64866	C	Fusion of facial/other nerve	.....	.....	.....	.....	.....
64868	C	Fusion of facial/other nerve	.....	.....	.....	.....	.....
64870	T	Fusion of facial/other nerve	632	18.13	$958.88	$461.04	$191.78
64872	T	Subsequent repair of nerve	632	18.13	$958.88	$461.04	$191.78
64874	T	Repair & revise nerve	632	18.13	$958.88	$461.04	$191.78
64876	T	Repair nerve; shorten bone	632	18.13	$958.88	$461.04	$191.78
64885	T	Nerve graft, head or neck	632	18.13	$958.88	$461.04	$191.78
64886	T	Nerve graft, head or neck	632	18.13	$958.88	$461.04	$191.78
64890	T	Nerve graft, hand or foot	632	18.13	$958.88	$461.04	$191.78
64891	T	Nerve graft, hand or foot	632	18.13	$958.88	$461.04	$191.78
64892	T	Nerve graft, arm or leg	632	18.13	$958.88	$461.04	$191.78
64893	T	Nerve graft, arm or leg	632	18.13	$958.88	$461.04	$191.78
64895	T	Nerve graft, hand or foot	632	18.13	$958.88	$461.04	$191.78
64896	T	Nerve graft, hand or foot	632	18.13	$958.88	$461.04	$191.78
64897	T	Nerve graft, arm or leg	632	18.13	$958.88	$461.04	$191.78
64898	T	Nerve graft, arm or leg	632	18.13	$958.88	$461.04	$191.78
64901	T	Additional nerve graft	632	18.13	$958.88	$461.04	$191.78
64902	T	Additional nerve graft	632	18.13	$958.88	$461.04	$191.78
64905	T	Nerve pedicle transfer	632	18.13	$958.88	$461.04	$191.78
64907	T	Nerve pedicle transfer	632	18.13	$958.88	$461.04	$191.78
64999	T	Nervous system surgery	601	3.11	$164.55	$74.13	$32.91
65091	T	Revise eye	684	13.48	$713.04	$348.94	$142.61
65093	T	Revise eye with implant	684	13.48	$713.04	$348.94	$142.61
65101	T	Removal of eye	684	13.48	$713.04	$348.94	$142.61
65103	T	Remove eye/insert implant	684	13.48	$713.04	$348.94	$142.61
65105	T	Remove eye/attach implant	684	13.48	$713.04	$348.94	$142.61
65110	C	Removal of eye	.....	.....	.....	.....	.....
65112	C	Remove eye, revise socket	.....	.....	.....	.....	.....
65114	C	Remove eye, revise socket	.....	.....	.....	.....	.....
65125	T	Revise ocular implant	681	1.67	$88.15	$30.51	$17.63
65130	T	Insert ocular implant	684	13.48	$713.04	$348.94	$142.61
65135	T	Insert ocular implant	684	13.48	$713.04	$348.94	$142.61
65140	T	Attach ocular implant	684	13.48	$713.04	$348.94	$142.61
65150	T	Revise ocular implant	684	13.48	$713.04	$348.94	$142.61
65155	T	Reinsert ocular implant	684	13.48	$713.04	$348.94	$142.61
65175	T	Removal of ocular implant	683	10.19	$538.7	$257.87	$107.74
65205	T	Remove foreign body from eye	681	1.67	$88.15	$30.51	$17.63
65210	T	Remove foreign body from eye	681	1.67	$88.15	$30.51	$17.63
65220	T	Remove foreign body from eye	681	1.67	$88.15	$30.51	$17.63
65222	T	Remove foreign body from eye	681	1.67	$88.15	$30.51	$17.63
65235	T	Remove foreign body from eye	652	16.48	$871.71	$433.69	$174.34
65260	T	Remove foreign body from eye	676	6.30	$333.01	$140.35	$66.60
65265	T	Remove foreign body from eye	676	6.30	$333.01	$140.35	$66.60
65270	T	Repair of eye wound	183	11.17	$590.61	$286.57	$118.12
65272	T	Repair of eye wound	651	7.24	$382.97	$174.70	$76.59
65273	C	Repair of eye wound	.....	.....	.....	.....	.....
65275	T	Repair of eye wound	651	7.24	$382.97	$174.70	$76.59
65280	T	Repair of eye wound	652	16.48	$871.71	$433.69	$174.34
65285	T	Repair of eye wound	652	16.48	$871.71	$433.69	$174.34
65286	T	Repair of eye wound	651	7.24	$382.97	$174.70	$76.59
65290	T	Repair of eye socket wound	677	16.26	$859.96	$436.63	$171.99
65400	T	Removal of eye lesion	652	16.48	$871.71	$433.69	$174.34
65410	T	Biopsy of cornea	683	10.19	$538.70	$257.87	$107.74
65420	T	Removal of eye lesion	651	7.24	$382.97	$174.70	$76.59
65426	T	Removal of eye lesion	652	16.48	$871.71	$433.69	$174.34
65430	T	Corneal smear	681	1.67	$88.15	$30.51	$17.63
65435	T	Curette/treat cornea	681	1.67	$88.15	$30.51	$17.63
65436	T	Curette/treat cornea	651	7.24	$382.97	$174.70	$76.59
65450	T	Treatment of corneal lesion	651	7.24	$382.97	$174.70	$76.59
65600	T	Revision of cornea	681	1.67	$88.15	$30.51	$17.63
65710	T	Corneal transplant	670	29.24	$1,546.56	$847.50	$309.31
65730	T	Corneal transplant	670	29.24	$1,546.56	$847.50	$309.31

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
65750	T	Corneal transplant	670	29.24	$1,546.56	$847.50	$309.31
65755	T	Corneal transplant	670	29.24	$1,546.56	$847.50	$309.31
65760	E	Revision of cornea	.....	.....	.....	.....	.....
65765	E	Revision of cornea	.....	.....	.....	.....	.....
65767	E	Corneal tissue transplant	.....	.....	.....	.....	.....
65770	T	Revise cornea with implant	652	16.48	$871.71	$433.69	$174.34
65771	E	Radial keratotomy	.....	.....	.....	.....	.....
65772	T	Correction of astigmatism	651	7.24	$382.97	$174.70	$76.59
65775	T	Correction of astigmatism	652	16.48	$871.71	$433.69	$174.34
65800	T	Drainage of eye	683	10.19	$538.70	$257.87	$107.74
65805	T	Drainage of eye	683	10.19	$538.70	$257.87	$107.74
65810	T	Drainage of eye	651	7.24	$382.97	$174.70	$76.59
65815	T	Drainage of eye	651	7.24	$382.97	$174.70	$76.59
65820	T	Relieve inner eye pressure	651	7.24	$382.97	$174.70	$76.59
65850	T	Incision of eye	652	16.48	$871.71	$433.69	$174.34
65855	T	Laser surgery of eye	649	4.44	$235.07	$111.64	$47.01
65860	T	Incise inner eye adhesions	649	4.44	$235.07	$111.64	$47.01
65865	T	Incise inner eye adhesions	652	16.48	$871.71	$433.69	$174.34
65870	T	Incise inner eye adhesions	652	16.48	$871.71	$433.69	$174.34
65875	T	Incise inner eye adhesions	652	16.48	$871.71	$433.69	$174.34
65880	T	Incise inner eye adhesions	652	16.48	$871.71	$433.69	$174.34
65900	T	Remove eye lesion	652	16.48	$871.71	$433.69	$174.34
65920	T	Remove implant from eye	652	16.48	$871.71	$433.69	$174.34
65930	T	Remove blood clot from eye	652	16.48	$871.71	$433.69	$174.34
66020	T	Injection treatment of eye	683	10.19	$538.70	$257.87	$107.74
66030	T	Injection treatment of eye	683	10.19	$538.70	$257.87	$107.74
66130	T	Remove eye lesion	651	7.24	$382.97	$174.70	$76.59
66150	T	Glaucoma surgery	652	16.48	$871.71	$433.69	$174.34
66155	T	Glaucoma surgery	652	16.48	$871.71	$433.69	$174.34
66160	T	Glaucoma surgery	652	16.48	$871.71	$433.69	$174.34
66165	T	Glaucoma surgery	652	16.48	$871.71	$433.69	$174.34
66170	T	Glaucoma surgery	652	16.48	$871.71	$433.69	$174.34
66172	T	Incision of eye	652	16.48	$871.71	$433.69	$174.34
66180	T	Implant eye shunt	652	16.48	$871.71	$433.69	$174.34
66185	T	Revise eye shunt	652	16.48	$871.71	$433.69	$174.34
66220	T	Repair eye lesion	676	6.30	$333.01	$140.35	$66.60
66225	T	Repair/graft eye lesion	652	16.48	$871.71	$433.69	$174.34
66250	T	Follow-up surgery of eye	652	16.48	$871.71	$433.69	$174.34
66500	T	Incision of iris	651	7.24	$382.97	$174.70	$76.59
66505	T	Incision of iris	651	7.24	$382.97	$174.70	$76.59
66600	T	Remove iris and lesion	651	7.24	$382.97	$174.70	$76.59
66605	T	Removal of iris	652	16.48	$871.71	$433.69	$174.34
66625	T	Removal of iris	651	7.24	$382.97	$174.70	$76.59
66630	T	Removal of iris	651	7.24	$382.97	$174.70	$76.59
66635	T	Removal of iris	652	16.48	$871.71	$433.69	$174.34
66680	T	Repair iris & ciliary body	652	16.48	$871.71	$433.69	$174.34
66682	T	Repair iris and ciliary body	652	16.48	$871.71	$433.69	$174.34
66700	T	Destruction, ciliary body	651	7.24	$382.97	$174.70	$76.59
66710	T	Destruction, ciliary body	651	7.24	$382.97	$174.70	$76.59
66720	T	Destruction, ciliary body	651	7.24	$382.97	$174.70	$76.59
66740	T	Destruction, ciliary body	652	16.48	$871.71	$433.69	$174.34
66761	T	Revision of iris	649	4.44	$235.07	$111.64	$47.01
66762	T	Revision of iris	649	4.44	$235.07	$111.64	$47.01
66770	T	Removal of inner eye lesion	649	4.44	$235.07	$111.64	$47.01
66820	T	Incision, secondary cataract	651	7.24	$382.97	$174.70	$76.59
66821	T	After cataract laser surgery	649	4.44	$235.07	$111.64	$47.01
66825	T	Reposition intraocular lens	651	7.24	$382.97	$174.70	$76.59
66830	T	Removal of lens lesion	652	16.48	$871.71	$433.69	$174.34
66840	T	Removal of lens material	667	19.28	$1,019.61	$521.83	$203.92
66850	T	Removal of lens material	667	19.28	$1,019.61	$521.83	$203.92
66852	T	Removal of lens material	667	19.28	$1,019.61	$521.83	$203.92
66920	T	Extraction of lens	667	19.28	$1,019.61	$521.83	$203.92
66930	T	Extraction of lens	667	19.28	$1,019.61	$521.83	$203.92
66940	T	Extraction of lens	667	19.28	$1,019.61	$521.83	$203.92
66983	T	Remove cataract, insert lens	668	19.28	$1,019.61	$530.87	$203.92
66984	T	Remove cataract, insert lens	668	19.28	$1,019.61	$530.87	$203.92
66985	T	Insert lens prosthesis	668	19.28	$1,019.61	$530.87	$203.92
66986	T	Exchange lens prosthesis	668	19.28	$1,019.61	$530.87	$203.92
66999	T	Eye surgery procedure	649	4.44	$235.07	$111.64	$47.01
67005	T	Partial removal of eye fluid	676	6.30	$333.01	$140.35	$66.60
67010	T	Partial removal of eye fluid	676	6.30	$333.01	$140.35	$66.60
67015	T	Release of eye fluid	676	6.30	$333.01	$140.35	$66.60
67025	T	Replace eye fluid	683	10.19	$538.70	$257.87	$107.74
67027	T	Implant eye drug system	690	30.54	$1,615.12	$852.02	$323.02
67028	T	Injection eye drug	682	3.54	$187.08	$81.36	$37.42

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
67030	T	Incise inner eye strands	676	6.30	$333.01	$140.35	$66.60
67031	T	Laser surgery, eye strands	649	4.44	$235.07	$111.64	$47.01
67036	T	Removal of inner eye fluid	690	30.54	$1,615.12	$852.02	$323.02
67038	T	Strip retinal membrane	690	30.54	$1,615.12	$852.02	$323.02
67039	T	Laser treatment of retina	690	30.54	$1,615.12	$852.02	$323.02
67040	T	Laser treatment of retina	690	30.54	$1,615.12	$852.02	$323.02
67101	T	Repair, detached retina	676	6.30	$333.01	$140.35	$66.60
67105	T	Repair, detached retina	648	3.94	$208.62	$95.15	$41.72
67107	T	Repair detached retina	690	30.54	$1,615.12	$852.02	$323.02
67108	T	Repair detached retina	690	30.54	$1,615.12	$852.02	$323.02
67110	T	Repair detached retina	676	6.30	$333.01	$140.35	$66.60
67112	T	Re-repair detached retina	690	30.54	$1,615.12	$852.02	$323.02
67115	T	Release, encircling material	676	6.30	$333.01	$140.35	$66.60
67120	T	Remove eye implant material	676	6.30	$333.01	$140.35	$66.60
67121	T	Remove eye implant material	676	6.30	$333.01	$140.35	$66.60
67141	T	Treatment of retina	676	6.30	$333.01	$140.35	$66.60
67145	T	Treatment of retina	648	3.94	$208.62	$95.15	$41.72
67208	T	Treatment of retinal lesion	676	6.30	$333.01	$140.35	$66.60
67210	T	Treatment of retinal lesion	648	3.94	$208.62	$95.15	$41.72
67218	T	Treatment of retinal lesion	676	6.30	$333.01	$140.35	$66.60
67227	T	Treatment of retinal lesion	676	6.30	$333.01	$140.35	$66.60
67228	T	Treatment of retinal lesion	648	3.94	$208.62	$95.15	$41.72
67250	T	Reinforce eye wall	684	13.48	$713.04	$348.94	$142.61
67255	T	Reinforce/graft eye wall	684	13.48	$713.04	$348.94	$142.61
67299	T	Eye surgery procedure	649	4.44	$235.07	$111.64	$47.01
67311	T	Revise eye muscle	677	16.26	$859.96	$436.63	$171.99
67312	T	Revise two eye muscles	677	16.26	$859.96	$436.63	$171.99
67314	T	Revise eye muscle	677	16.26	$859.96	$436.63	$171.99
67316	T	Revise two eye muscles	677	16.26	$859.96	$436.63	$171.99
67318	T	Revise eye muscle(s)	677	16.26	$859.96	$436.63	$171.99
67320	T	Revise eye muscle(s)	677	16.26	$859.96	$436.63	$171.99
67331	T	Eye surgery follow-up	677	16.26	$859.96	$436.63	$171.99
67332	T	Rerevise eye muscles	677	16.26	$859.96	$436.63	$171.99
67334	T	Revise eye muscle w/suture	677	16.26	$859.96	$436.63	$171.99
67335	T	Eye suture during surgery	677	16.26	$859.96	$436.63	$171.99
67340	T	Revise eye muscle	677	16.26	$859.96	$436.63	$171.99
67343	T	Release eye tissue	677	16.26	$859.96	$436.63	$171.99
67345	T	Destroy nerve of eye muscle	681	1.67	$88.15	$30.51	$17.63
67350	T	Biopsy eye muscle	162	5.67	$299.71	$125.43	$59.94
67399	T	Eye muscle surgery procedure	162	5.67	$299.71	$125.43	$59.94
67400	T	Explore/biopsy eye socket	684	13.48	$713.04	$348.94	$142.61
67405	T	Explore/drain eye socket	684	13.48	$713.04	$348.94	$142.61
67412	T	Explore/treat eye socket	684	13.48	$713.04	$348.94	$142.61
67413	T	Explore/treat eye socket	684	13.48	$713.04	$348.94	$142.61
67414	C	Explore/decompress eye socke	.....	.....	.....	.....	.....
67415	T	Aspiration orbital contents	122	$4.87	$257.60	$115.03	$51.52
67420	T	Explore/treat eye socket	232	23.93	$1,265.45	$639.35	$253.09
67430	T	Explore/treat eye socket	232	23.93	$1,265.45	$639.35	$253.09
67440	T	Explore/drain eye socket	232	23.93	$1,265.45	$639.35	$253.09
67445	C	Explore/decompress eye socke	.....	.....	.....	.....	.....
67450	T	Explore/biopsy eye socket	232	23.93	$1,265.45	$639.35	$253.09
67500	T	Inject/treat eye socket	681	1.67	$88.15	$30.51	$17.63
67505	T	Inject/treat eye socket	681	1.67	$88.15	$30.51	$17.63
67515	T	Inject/treat eye socket	681	1.67	$88.15	$30.51	$17.63
67550	T	Insert eye socket implant	684	13.48	$713.04	$348.94	$142.61
67560	T	Revise eye socket implant	684	13.48	$713.04	$348.94	$142.61
67570	C	Decompress optic nerve	.....	.....	.....	.....	.....
67599	T	Orbit surgery procedure	681	1.67	$88.15	$30.51	$17.63
67700	T	Drainage of eyelid abscess	682	3.54	$187.08	$81.36	$37.42
67710	T	Incision of eyelid	682	3.54	$187.08	$81.36	$37.42
67715	T	Incision of eyelid fold	683	10.19	$538.76	$257.87	$107.74
67800	T	Remove eyelid lesion	682	3.54	$187.08	$81.36	$37.42
67801	T	Remove eyelid lesions	682	3.54	$187.08	$81.36	$37.42
67805	T	Remove eyelid lesions	682	3.54	$187.08	$81.36	$37.42
67808	T	Remove eyelid lesion(s)	684	13.48	$713.04	$348.94	$142.61
67810	T	Biopsy of eyelid	682	3.54	$187.08	$81.36	$37.42
67820	T	Revise eyelashes	682	3.54	$187.08	$81.36	$37.42
67825	T	Revise eyelashes	682	3.54	$187.08	$81.36	$37.42
67830	T	Revise eyelashes	683	10.19	$538.7	$257.87	$107.74
67835	T	Revise eyelashes	684	13.48	$713.04	$348.94	$142.61
67840	T	Remove eyelid lesion	682	3.54	$187.08	$81.36	$37.42
67850	T	Treat eyelid lesion	682	3.54	$187.08	$81.36	$37.42
67875	T	Closure of eyelid by suture	682	3.54	$187.08	$81.36	$37.42
67880	T	Revision of eyelid	683	10.19	$538.70	$257.87	$107.74
67882	T	Revision of eyelid	684	13.48	$713.04	$348.94	$142.61

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
67900	T	Repair brow defect	684	13.48	$713.04	$348.94	$142.61
67901	T	Repair eyelid defect	684	13.48	$713.04	$348.94	$142.61
67902	T	Repair eyelid defect	684	13.48	$713.04	$348.94	$142.61
67903	T	Repair eyelid defect	684	13.48	$713.04	$348.94	$142.61
67904	T	Repair eyelid defect	684	13.48	$713.04	$348.94	$142.61
67906	T	Repair eyelid defect	684	13.48	$713.04	$348.94	$142.61
67908	T	Repair eyelid defect	684	13.48	$713.04	$348.94	$142.61
67909	T	Revise eyelid defect	684	13.48	$713.04	$348.94	$142.61
67911	T	Revise eyelid defect	684	13.48	$713.04	$348.94	$142.61
67914	T	Repair eyelid defect	684	13.48	$713.04	$348.94	$142.61
67915	T	Repair eyelid defect	682	3.54	$187.08	$81.36	$37.42
67916	T	Repair eyelid defect	684	13.48	$713.04	$348.94	$142.61
67917	T	Repair eyelid defect	684	13.48	$713.04	$348.94	$142.61
67921	T	Repair eyelid defect	684	13.48	$713.04	$348.94	$142.61
67922	T	Repair eyelid defect	682	3.54	$187.08	$81.36	$37.42
67923	T	Repair eyelid defect	684	13.48	$713.04	$348.94	$142.61
67924	T	Repair eyelid defect	684	13.48	$713.04	$348.94	$142.61
67930	T	Repair eyelid wound	682	3.54	$187.08	$81.36	$37.42
67935	T	Repair eyelid wound	683	10.19	$538.70	$257.87	$107.74
67938	T	Remove eyelid foreign body	682	3.54	$187.08	$81.36	$37.42
67950	T	Revision of eyelid	684	13.48	$713.04	$348.94	$142.61
67961	T	Revision of eyelid	684	13.48	$713.04	$348.94	$142.61
67966	T	Revision of eyelid	684	13.48	$713.04	$348.94	$142.61
67971	T	Reconstruction of eyelid	684	13.48	$713.04	$348.94	$142.61
67973	T	Reconstruction of eyelid	684	13.48	$713.04	$348.94	$142.61
67974	T	Reconstruction of eyelid	684	13.48	$713.04	$348.94	$142.61
67975	T	Reconstruction of eyelid	684	13.48	$713.04	$348.94	$142.61
67999	T	Revision of eyelid	682	3.54	$187.08	$81.36	$37.42
68020	T	Incise/drain eyelid lining	682	3.54	$187.08	$81.36	$37.42
68040	T	Treatment of eyelid lesions	682	3.54	$187.08	$81.36	$37.42
68100	T	Biopsy of eyelid lining	162	5.67	$299.71	$125.43	$59.94
68110	T	Remove eyelid lining lesion	162	5.67	$299.71	$125.43	$59.94
68115	T	Remove eyelid lining lesion	162	5.67	$299.71	$125.43	$59.94
68130	T	Remove eyelid lining lesion	652	16.48	$871.71	$433.69	$174.34
68135	T	Remove eyelid lining lesion	162	5.67	$299.71	$125.43	$59.94
68200	T	Treat eyelid by injection	681	1.67	$88.15	$30.51	$17.63
68320	T	Revise/graft eyelid lining	684	13.48	$713.04	$348.94	$142.61
68325	T	Revise/graft eyelid lining	684	13.48	$713.04	$348.94	$142.61
68326	T	Revise/graft eyelid lining	684	13.48	$713.04	$348.94	$142.61
68328	T	Revise/graft eyelid lining	684	13.48	$713.04	$348.94	$142.61
68330	T	Revise eyelid lining	652	16.48	$871.71	$433.69	$174.34
68335	T	Revise/graft eyelid lining	684	13.48	$713.04	$348.94	$142.61
68340	T	Separate eyelid adhesions	684	13.48	$713.04	$348.94	$142.61
68360	T	Revise eyelid lining	652	16.48	$871.71	$433.69	$174.34
68362	T	Revise eyelid lining	652	16.48	$871.71	$433.69	$174.34
68399	T	Eyelid lining surgery	162	5.67	$299.71	$125.43	$59.94
68400	T	Incise/drain tear gland	682	3.54	$187.08	$81.36	$37.42
68420	T	Incise/drain tear sac	682	3.54	$187.08	$81.36	$37.42
68440	T	Incise tear duct opening	682	3.54	$187.08	$81.36	$37.42
68500	T	Removal of tear gland	684	13.48	$713.04	$348.94	$142.61
68505	T	Partial removal tear gland	684	13.48	$713.04	$348.94	$142.61
68510	T	Biopsy of tear gland	683	10.19	$538.70	$257.87	$107.74
68520	T	Removal of tear sac	684	13.48	$713.04	$348.94	$142.61
68525	T	Biopsy of tear sac	683	10.19	$538.70	$257.87	$107.74
68530	T	Clearance of tear duct	682	3.54	$187.08	$81.36	$37.42
68540	T	Remove tear gland lesion	684	13.48	$713.04	$348.94	$142.61
68550	T	Remove tear gland lesion	684	13.48	$713.04	$348.94	$142.61
68700	T	Repair tear ducts	684	13.48	$713.04	$348.94	$142.61
68705	T	Revise tear duct opening	682	3.54	$187.08	$81.36	$37.42
68720	T	Create tear sac drain	684	13.48	$713.04	$348.94	$142.61
68745	T	Create tear duct drain	684	13.48	$713.04	$348.94	$142.61
68750	T	Create tear duct drain	684	13.48	$713.04	$348.94	$142.61
68760	T	Close tear duct opening	682	3.54	$187.08	$81.36	$37.42
68761	T	Close tear duct opening	681	1.67	$88.15	$30.51	$17.63
68770	T	Close tear system fistula	684	13.48	$713.04	$348.94	$142.61
68801	T	Dilate tear duct opening	682	3.54	$187.08	$81.36	$37.42
68810	T	Probe nasolacrimal duct	683	10.19	$538.70	$257.87	$107.74
68811	T	Probe nasolacrimal duct	684	13.48	$713.04	$348.94	$142.61
68815	T	Probe nasolacrimal duct	684	13.48	$713.04	$348.94	$142.61
68840	T	Explore/irrigate tear ducts	682	3.54	$187.08	$81.36	$37.42
68850	T	Injection for tear sac x-ray	347	2.93	$154.75	$62.15	$30.95
68899	T	Tear duct system surgery	681	1.67	$88.15	$30.51	$17.63
69000	T	Drain external ear lesion	131	1.94	$102.84	$36.61	$20.57
69005	T	Drain external ear lesion	131	1.94	$102.84	$36.61	$20.57
69020	T	Drain outer ear canal lesion	131	1.94	$102.84	$36.61	$20.57

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
69090	E	Pierce earlobes	.....	.....	.....	.....	.....
69100	T	Biopsy of external ear	161	3.50	$185.12	$75.48	$37.02
69105	T	Biopsy of external ear canal	161	3.50	$185.12	$75.48	$37.02
69110	T	Partial removal external ear	163	10.69	$565.14	$264.65	$113.03
69120	T	Removal of external ear	313	15.81	$836.45	$411.09	$167.29
69140	T	Remove ear canal lesion(s)	313	15.81	$836.45	$411.09	$167.29
69145	T	Remove ear canal lesion(s)	163	10.69	$565.14	$264.65	$113.03
69150	T	Extensive ear canal surgery	314	25.65	$1,356.54	$693.37	$271.31
69155	C	Extensive ear/neck surgery	.....	.....	.....	.....	.....
69200	T	Clear outer ear canal	311	1.43	$75.42	$20.57	$15.08
69205	T	Clear outer ear canal	163	10.69	$565.14	$264.65	$113.03
69210	T	Remove impacted ear wax	311	1.43	$75.42	$20.57	$15.08
69220	T	Clean out mastoid cavity	151	1.74	$92.07	$35.71	$18.41
69222	T	Clean out mastoid cavity	311	1.43	$75.42	$20.57	$15.08
69300	T	Revise external ear	313	15.81	$836.45	$411.09	$167.29
69310	T	Rebuild outer ear canal	314	25.65	$1,356.54	$693.37	$271.31
69320	T	Rebuild outer ear canal	314	25.65	$1,356.54	$693.37	$271.31
69399	T	Outer ear surgery procedure	311	1.43	$75.42	$20.57	$15.08
69400	T	Inflate middle ear canal	311	1.43	$75.42	$20.57	$15.08
69401	N	Inflate middle ear canal	.....	.....	.....	.....	.....
69405	T	Catheterize middle ear canal	311	1.43	$75.42	$20.57	$15.08
69410	T	Inset middle ear baffle	311	1.43	$75.42	$20.57	$15.08
69420	T	Incision of eardrum	311	1.43	$75.42	$20.57	$15.08
69421	T	Incision of eardrum	312	7.26	$383.95	$178.31	$76.79
69424	T	Remove ventilating tube	311	1.43	$75.42	$20.57	$15.08
69433	T	Create eardrum opening	312	7.26	$383.95	$178.31	$76.79
69436	T	Create eardrum opening	312	7.26	$383.95	$178.31	$76.79
69440	T	Exploration of middle ear	313	15.81	$836.45	$411.09	$167.29
69450	T	Eardrum revision	313	15.81	$836.45	$411.09	$167.29
69501	T	Mastoidectomy	314	25.65	$1,356.54	$693.37	$271.31
69502	T	Mastoidectomy	314	25.65	$1,356.54	$693.37	$271.31
69505	T	Remove mastoid structures	314	25.65	$1,356.54	$693.37	$271.31
69511	T	Extensive mastoid surgery	314	25.65	$1,356.54	$693.37	$271.31
69530	T	Extensive mastoid surgery	314	25.65	$1,356.54	$693.37	$271.31
69535	C	Remove part of temporal bone	.....	.....	.....	.....	.....
69540	T	Remove ear lesion	311	1.43	$75.42	$20.57	$15.08
69550	T	Remove ear lesion	314	25.65	$1,356.54	$693.37	$271.31
69552	T	Remove ear lesion	314	25.65	$1,356.54	$693.37	$271.31
69554	C	Remove ear lesion	.....	.....	.....	.....	.....
69601	T	Mastoid surgery revision	314	25.65	$1,356.54	$693.37	$271.31
69602	T	Mastoid surgery revision	314	25.65	$1,356.54	$693.37	$271.31
69603	T	Mastoid surgery revision	314	25.65	$1,356.54	$693.37	$271.31
69604	T	Mastoid surgery revision	314	25.65	$1,356.54	$693.37	$271.31
69605	T	Mastoid surgery revision	314	25.65	$1,356.54	$693.37	$271.31
69610	T	Repair of eardrum	311	1.43	$75.42	$20.57	$15.08
69620	T	Repair of eardrum	313	15.81	$836.45	$411.09	$167.29
69631	T	Repair eardrum structures	314	25.65	$1,356.54	$693.37	$271.31
69632	T	Rebuild eardrum structures	314	25.65	$1,356.54	$693.37	$271.31
69633	T	Rebuild eardrum structures	314	25.65	$1,356.54	$693.37	$271.31
69635	T	Repair eardrum structures	314	25.65	$1,356.54	$693.37	$271.31
69636	T	Rebuild eardrum structures	314	25.65	$1,356.54	$693.37	$271.31
69637	T	Rebuild eardrum structures	314	25.65	$1,356.54	$693.37	$271.31
69641	T	Revise middle ear & mastoid	314	25.65	$1,356.54	$693.37	$271.31
69642	T	Revise middle ear & mastoid	314	25.65	$1,356.54	$693.37	$271.31
69643	T	Revise middle ear & mastoid	314	25.65	$1,356.54	$693.37	$271.31
69644	T	Revise middle ear & mastoid	314	25.65	$1,356.54	$693.37	$271.31
69645	T	Revise middle ear & mastoid	314	25.65	$1,356.54	$693.37	$271.31
69646	T	Revise middle ear & mastoid	314	25.65	$1,356.54	$693.37	$271.31
69650	T	Release middle ear bone	314	25.65	$1,356.54	$693.37	$271.31
69660	T	Revise middle ear bone	314	25.65	$1,356.54	$693.37	$271.31
69661	T	Revise middle ear bone	314	25.65	$1,356.54	$693.37	$271.31
69662	T	Revise middle ear bone	314	25.65	$1,356.54	$693.37	$271.31
69666	T	Repair middle ear structures	314	25.65	$1,356.54	$693.37	$271.31
69667	T	Repair middle ear structures	314	25.65	$1,356.54	$693.37	$271.31
69670	T	Remove mastoid air cells	314	25.65	$1,356.54	$693.37	$271.31
69676	T	Remove middle ear nerve	314	25.65	$1,356.54	$693.37	$271.31
69700	T	Close mastoid fistula	314	25.65	$1,356.54	$693.37	$271.31
69710	E	Implant/replace hearing aid	.....	.....	.....	.....	.....
69711	T	Remove/repair hearing aid	314	25.65	$1,356.54	$693.37	$271.31
69720	T	Release facial nerve	314	25.65	$1,356.54	$693.37	$271.31
69725	T	Release facial nerve	314	25.65	$1,356.54	$693.37	$271.31
69740	T	Repair facial nerve	314	25.65	$1,356.54	$693.37	$271.31
69745	T	Repair facial nerve	314	25.65	$1,356.54	$693.37	$271.31
69799	T	Middle ear surgery procedure	311	1.43	$75.42	$20.57	$15.08
69801	T	Incise inner ear	314	25.65	$1,356.54	$693.37	$271.31

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
69802	T	Incise inner ear	314	25.65	$1,356.54	$693.37	$271.31
69805	T	Explore inner ear	314	25.65	$1,356.54	$693.37	$271.31
69806	T	Explore inner ear	314	25.65	$1,356.54	$693.37	$271.31
69820	T	Establish inner ear window	314	25.65	$1,356.54	$693.37	$271.31
69840	T	Revise inner ear window	314	25.65	$1,356.54	$693.37	$271.31
69905	T	Remove inner ear	314	25.65	$1,356.54	$693.37	$271.31
69910	T	Remove inner ear & mastoid	314	25.65	$1,356.54	$693.37	$271.31
69915	T	Incise inner ear nerve	314	25.65	$1,356.54	$693.37	$271.31
69930	T	Implant cochlear device	317	.....	.....	.....	.....
69949	T	Inner ear surgery procedure	314	25.65	$1,356.54	$693.37	$271.31
69950	C	Incise inner ear nerve	.....	.....	.....	.....	.....
69955	C	Release facial nerve	.....	.....	.....	.....	.....
69960	C	Release inner ear canal	.....	.....	.....	.....	.....
69970	C	Remove inner ear lesion	.....	.....	.....	.....	.....
69979	C	Temporal bone surgery	.....	.....	.....	.....	.....
70010	S	Contrast x-ray of brain	728	4.07	$215.48	$113.23	$43.10
70015	S	Contrast x-ray of brain	728	4.07	$215.48	$113.23	$43.10
70030	X	X-ray eye for foreign body	700	0.78	$41.14	$22.37	$8.23
70100	X	X-ray exam of jaw	700	0.78	$41.14	$22.37	$8.23
70110	X	X-ray exam of jaw	700	0.78	$41.14	$22.37	$8.23
70120	X	X-ray exam of mastoids	700	0.78	$41.14	$22.37	$8.23
70130	X	X-ray exam of mastoids	700	0.78	$41.14	$22.37	$8.23
70134	X	X-ray exam of middle ear	700	0.78	$41.14	$22.37	$8.23
70140	X	X-ray exam of facial bones	700	0.78	$41.14	$22.37	$8.23
70150	X	X-ray exam of facial bones	700	0.78	$41.14	$22.37	$8.23
70160	X	X-ray exam of nasal bones	700	0.78	$41.14	$22.37	$8.23
70170	X	X-ray exam of tear duct	706	1.96	$103.82	$57.63	$20.76
70190	X	X-ray exam of eye sockets	700	0.78	$41.14	$22.37	$8.23
70200	X	X-ray exam of eye sockets	700	0.78	$41.14	$22.37	$8.23
70210	X	X-ray exam of sinuses	700	0.78	$41.14	$22.37	$8.23
70220	X	X-ray exam of sinuses	700	0.78	$41.14	$22.37	$8.23
70240	X	X-ray exam pituitary saddle	700	0.78	$41.14	$22.37	$8.23
70250	X	X-ray exam of skull	700	0.78	$41.14	$22.37	$8.23
70260	X	X-ray exam of skull	700	0.78	$41.14	$22.37	$8.23
70300	X	X-ray exam of teeth	700	0.78	$41.14	$22.37	$8.23
70310	X	X-ray exam of teeth	700	0.78	$41.14	$22.37	$8.23
70320	X	Full mouth x-ray of teeth	700	0.78	$41.14	$22.37	$8.23
70328	X	X-ray exam of jaw joint	700	0.78	$41.14	$22.37	$8.23
70330	X	X-ray exam of jaw joints	700	0.78	$41.14	$22.37	$8.23
70332	S	X-ray exam of jaw joint	730	2.48	$131.25	$72.09	$26.25
70336	S	Magnetic image jaw joint	726	7.96	$421.16	$258.09	$84.23
70350	X	X-ray head for orthodontia	700	0.78	$41.14	$22.37	$8.23
70355	X	Panoramic x-ray of jaws	700	0.78	$41.14	$22.37	$8.23
70360	X	X-ray exam of neck	700	0.78	$41.14	$22.37	$8.23
70370	X	Throat x-ray & fluoroscopy	716	1.59	$84.23	$47.91	$16.85
70371	X	Speech evaluation, complex	716	1.59	$84.23	$47.91	$16.85
70373	X	Contrast x-ray of larynx	706	1.96	$103.82	$57.63	$20.76
70380	X	X-ray exam of salivary gland	700	0.78	$41.14	$22.37	$8.23
70390	X	X-ray exam of salivary duct	706	1.96	$103.82	$57.63	$20.76
70450	S	CAT scan of head or brain	710	5.06	$267.39	$176.28	$53.48
70460	S	Contrast CAT scan of head	710	5.06	$267.39	$176.28	$53.48
70470	S	Contrast CAT scans of head	710	5.06	$267.39	$176.28	$53.48
70480	S	CAT scan of skull	710	5.06	$267.39	$176.28	$53.48
70481	S	Contrast CAT scan of skull	710	5.06	$267.39	$176.28	$53.48
70482	S	Contrast CAT scans of skull	710	5.06	$267.39	$176.28	$53.48
70486	S	CAT scan of face, jaw	710	5.06	$267.39	$176.28	$53.48
70487	S	Contrast CAT scan, face/jaw	710	5.06	$267.39	$176.28	$53.48
70488	S	Contrast CAT scans face/jaw	710	5.06	$267.39	$176.28	$53.48
70490	S	CAT scan of neck tissue	710	5.06	$267.39	$176.28	$53.48
70491	S	Contrast CAT of neck tissue	710	5.06	$267.39	$176.28	$53.48
70492	S	Contrast CAT of neck tissue	710	5.06	$267.39	$176.28	$53.48
70540	S	Magnetic image, face, neck	726	7.96	$421.16	$258.09	$84.23
70541	S	Magnetic image, head (MRA)	720	6.35	$335.95	$206.11	$67.19
70551	S	Magnetic image, brain (MRI)	726	7.96	$421.16	$258.09	$84.23
70552	S	Magnetic image, brain (MRI)	726	7.96	$421.16	$258.09	$84.23
70553	S	Magnetic image, brain	726	7.96	$421.16	$258.09	$84.23
71010	X	Chest x-ray	700	0.78	$41.14	$22.37	$8.23
71015	X	X-ray exam of chest	700	0.78	$41.14	$22.37	$8.23
71020	X	Chest x-ray	700	0.78	$41.14	$22.37	$8.23
71021	X	Chest x-ray	700	0.78	$41.14	$22.37	$8.23
71022	X	Chest x-ray	700	0.78	$41.14	$22.37	$8.23
71023	X	Chest x-ray and fluoroscopy	716	1.59	$84.23	$47.91	$16.85
71030	X	Chest x-ray	700	0.78	$41.14	$22.37	$8.23
71034	X	Chest x-ray & fluoroscopy	716	1.59	$84.23	$47.91	$16.85
71035	X	Chest x-ray	700	0.78	$41.14	$22.37	$8.23

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
71036	X	X-ray guidance for biopsy	716	1.59	$84.23	$47.91	$16.85
71038	X	X-ray guidance for biopsy	716	1.59	$84.23	$47.91	$16.85
71040	X	Contrast x-ray of bronchi	706	1.96	$103.82	$57.63	$20.76
71060	X	Contrast x-ray of bronchi	706	1.96	$103.82	$57.63	$20.76
71090	X	X-ray & pacemaker insertion	716	1.59	$84.23	$47.91	$16.85
71100	X	X-ray exam of ribs	700	0.78	$41.14	$22.37	$8.23
71101	X	X-ray exam of ribs, chest	700	0.78	$41.14	$22.37	$8.23
71110	X	X-ray exam of ribs	700	0.78	$41.14	$22.37	$8.23
71111	X	X-ray exam of ribs, chest	700	0.78	$41.14	$22.37	$8.23
71120	X	X-ray exam of breastbone	700	0.78	$41.14	$22.37	$8.23
71130	X	X-ray exam of breastbone	700	0.78	$41.14	$22.37	$8.23
71250	S	Cat scan of chest	710	5.06	$267.39	$176.28	$53.48
71260	S	Contrast CAT scan of chest	710	5.06	$267.39	$176.28	$53.48
71270	S	Contrast CAT scans of chest	710	5.06	$267.39	$176.28	$53.48
71550	S	Magnetic image, chest	726	7.96	$421.16	$258.09	$84.23
71555	E	Magnetic imaging/chest (MRA)	.....	.....	.....	.....	.....
72010	X	X-ray exam of spine	700	0.78	$41.14	$22.37	$8.23
72020	X	X-ray exam of spine	700	0.78	$41.14	$22.37	$8.23
72040	X	X-ray exam of neck spine	700	0.78	$41.14	$22.37	$8.23
72050	X	X-ray exam of neck spine	700	0.78	$41.14	$22.37	$8.23
72052	X	X-ray exam of neck spine	700	0.78	$41.14	$22.37	$8.23
72069	X	X-ray exam of trunk spine	700	0.78	$41.14	$22.37	$8.23
72070	X	X-ray exam of thorax spine	700	0.78	$41.14	$22.37	$8.23
72072	X	X-ray exam of thoracic spine	700	0.78	$41.14	$22.37	$8.23
72074	X	X-ray exam of thoracic spine	700	0.78	$41.14	$22.37	$8.23
72080	X	X-ray exam of trunk spine	700	0.78	$41.14	$22.37	$8.23
72090	X	X-ray exam of trunk spine	700	0.78	$41.14	$22.37	$8.23
72100	X	X-ray exam of lower spine	700	0.78	$41.14	$22.37	$8.23
72110	X	X-ray exam of lower spine	700	0.78	$41.14	$22.37	$8.23
72114	X	X-ray exam of lower spine	700	0.78	$41.14	$22.37	$8.23
72120	X	X-ray exam of lower spine	700	0.78	$41.14	$22.37	$8.23
72125	S	CAT scan of neck spine	710	5.06	$267.39	$176.28	$53.48
72126	S	Contrast CAT scan of neck	710	5.06	$267.39	$176.28	$53.48
72127	S	Contrast CAT scans of neck	710	5.06	$267.39	$176.28	$53.48
72128	S	CAT scan of thorax spine	710	5.06	$267.39	$176.28	$53.48
72129	S	Contrast CAT scan of thorax	710	5.06	$267.39	$176.28	$53.48
72130	S	Contrast CAT scans of thorax	710	5.06	$267.39	$176.28	$53.48
72131	S	CAT scan of lower spine	710	5.06	$267.39	$176.28	$53.48
72132	S	Contrast CAT of lower spine	710	5.06	$267.39	$176.28	$53.48
72133	S	Contrast CAT scans, low spine	710	5.06	$267.39	$176.28	$53.48
72141	S	Magnetic image, neck spine	726	7.96	$421.16	$258.09	$84.23
72142	S	Magnetic image, neck spine	726	7.96	$421.16	$258.09	$84.23
72146	S	Magnetic image, chest spine	726	7.96	$421.16	$258.09	$84.23
72147	S	Magnetic image, chest spine	726	7.96	$421.16	$258.09	$84.23
72148	S	Magnetic image, lumbar spine	726	7.96	$421.16	$258.09	$84.23
72149	S	Magnetic image, lumbar spine	726	7.96	$421.16	$258.09	$84.23
72156	S	Magnetic image, neck spine	726	7.96	$421.16	$258.09	$84.23
72157	S	Magnetic image, chest spine	726	7.96	$421.16	$258.09	$84.23
72158	S	Magnetic image, lumbar spine	726	7.96	$421.16	$258.09	$84.23
72159	E	Magnetic imaging/spine (MRA)	.....	.....	.....	.....	.....
72170	X	X-ray exam of pelvis	700	0.78	$41.14	$22.37	$8.23
72190	X	X-ray exam of pelvis	700	0.78	$41.14	$22.37	$8.23
72192	S	CAT scan of pelvis	710	5.06	$267.39	$176.28	$53.48
72193	S	Contrast CAT scan of pelvis	710	5.06	$267.39	$176.28	$53.48
72194	S	Contrast CAT scans of pelvis	710	5.06	$267.39	$176.28	$53.48
72196	S	Magnetic image, pelvis	726	7.96	$421.16	$258.09	$84.23
72198	E	Magnetic imaging/pelvis(MRA)	.....	.....	.....	.....	.....
72200	X	X-ray exam sacroiliac joints	700	0.78	$41.14	$22.37	$8.23
72202	X	X-ray exam sacroiliac joints	700	0.78	$41.14	$22.37	$8.23
72220	X	X-ray exam of tailbone	700	0.78	$41.14	$22.37	$8.23
72240	S	Contrast x-ray of neck spine	728	4.07	$215.48	$113.23	$43.10
72255	S	Contrast x-ray thorax spine	728	4.07	$215.48	$113.23	$43.10
72265	S	Contrast x-ray lower spine	728	4.07	$215.48	$113.23	$43.10
72270	S	Contrast x-ray of spine	728	4.07	$215.48	$113.23	$43.10
72285	S	X-ray of neck spine disk	728	4.07	$215.48	$113.23	$43.10
72295	S	X-ray of lower spine disk	728	4.07	$215.48	$113.23	$43.10
73000	X	X-ray exam of collarbone	700	0.78	$41.14	$22.37	$8.23
73010	X	X-ray exam of shoulderblade	700	0.78	$41.14	$22.37	$8.23
73020	X	X-ray exam of shoulder	700	0.78	$41.14	$22.37	$8.23
73030	X	X-ray exam of shoulder	700	0.78	$41.14	$22.37	$8.23
73040	S	Contrast x-ray of shoulder	730	2.48	$131.25	$72.09	$26.25
73050	X	X-ray exam of shoulders	700	0.78	$41.14	$22.37	$8.23
73060	X	X-ray exam of humerus	700	0.78	$41.14	$22.37	$8.23
73070	X	X-ray exam of elbow	700	0.78	$41.14	$22.37	$8.23
73080	X	X-ray exam of elbow	700	0.78	$41.14	$22.37	$8.23

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
73085	S	Contrast x-ray of elbow	730	2.48	$131.25	$72.09	$26.25
73090	X	X-ray exam of forearm	700	0.78	$41.14	$22.37	$8.23
73092	X	X-ray exam of arm, infant	700	0.78	$41.14	$22.37	$8.23
73100	X	X-ray exam of wrist	700	0.78	$41.14	$22.37	$8.23
73110	X	X-ray exam of wrist	700	0.78	$41.14	$22.37	$8.23
73115	S	Contrast x-ray of wrist	730	2.48	$131.25	$72.09	$26.25
73120	X	X-ray exam of hand	700	0.78	$41.14	$22.37	$8.23
73130	X	X-ray exam of hand	700	0.78	$41.14	$22.37	$8.23
73140	X	X-ray exam of finger(s)	700	0.78	$41.14	$22.37	$8.23
73200	S	CAT scan of arm	710	5.06	$267.39	$176.28	$53.48
73201	S	Contrast CAT scan of arm	710	5.06	$267.39	$176.28	$53.48
73202	S	Contrast CAT scans of arm	710	5.06	$267.39	$176.28	$53.48
73220	S	Magnetic image, arm, hand	726	7.96	$421.16	$258.09	$84.23
73221	S	Magnetic image, joint of arm	726	7.96	$421.16	$258.09	$84.23
73225	E	Magnetic imaging/upper (MRA)	.....	.....	.....	.....	.....
73500	X	X-ray exam of hip	700	0.78	$41.14	$22.37	$8.23
73510	X	X-ray exam of hip	700	0.78	$41.14	$22.37	$8.23
73520	X	X-ray exam of hips	700	0.78	$41.14	$22.37	$8.23
73525	S	Contrast x-ray of hip	730	2.48	$131.25	$72.09	$26.25
73530	X	X-ray exam of hip	700	0.78	$41.14	$22.37	$8.23
73540	X	X-ray exam of pelvis & hips	700	0.78	$41.14	$22.37	$8.23
73550	X	X-ray exam of thigh	700	0.78	$41.14	$22.37	$8.23
73560	X	X-ray exam of knee	700	0.78	$41.14	$22.37	$8.23
73562	X	X-ray exam of knee	700	0.78	$41.14	$22.37	$8.23
73564	X	X-ray exam of knee	700	0.78	$41.14	$22.37	$8.23
73565	X	X-ray exam of knee	700	0.78	$41.14	$22.37	$8.23
73580	S	Contrast x-ray of knee joint	730	2.48	$131.25	$72.09	$26.25
73590	X	X-ray exam of lower leg	700	0.78	$41.14	$22.37	$8.23
73592	X	X-ray exam of leg, infant	700	0.78	$41.14	$22.37	$8.23
73600	X	X-ray exam of ankle	700	0.78	$41.14	$22.37	$8.23
73610	X	X-ray exam of ankle	700	0.78	$41.14	$22.37	$8.23
73615	S	Contrast x-ray of ankle	730	2.48	$131.25	$72.09	$26.25
73620	X	X-ray exam of foot	700	0.78	$41.14	$22.37	$8.23
73630	X	X-ray exam of foot	700	0.78	$41.14	$22.37	$8.23
73650	X	X-ray exam of heel	700	0.78	$41.14	$22.37	$8.23
73660	X	X-ray exam of toe(s)	700	0.78	$41.14	$22.37	$8.23
73700	S	CAT scan of leg	710	5.06	$267.39	$176.28	$53.48
73701	S	Contrast CAT scan of leg	710	5.06	$267.39	$176.28	$53.48
73702	S	Contrast CAT scans of leg	710	5.06	$267.39	$176.28	$53.48
73720	S	Magnetic image, leg, foot	726	7.96	$421.16	$258.09	$84.23
73721	S	Magnetic image, joint of leg	726	7.96	$421.16	$258.09	$84.23
73725	E	Magnetic imaging/lower (MRA)	.....	.....	.....	.....	.....
74000	X	X-ray exam of abdomen	700	0.78	$41.14	$22.37	$8.23
74010	X	X-ray exam of abdomen	700	0.78	$41.14	$22.37	$8.23
74020	X	X-ray exam of abdomen	700	0.78	$41.14	$22.37	$8.23
74022	X	X-ray exam series, abdomen	700	0.78	$41.14	$22.37	$8.23
74150	S	CAT scan of abdomen	710	5.06	$267.39	$176.28	$53.48
74160	S	Contrast CAT scan of abdomen	710	5.06	$267.39	$176.28	$53.48
74170	S	Contrast CAT scans, abdomen	710	5.06	$267.39	$176.28	$53.48
74181	S	Magnetic image,abdomen (MRI)	726	7.96	$421.16	$258.09	$84.23
74185	E	Magnetic image/abdomen (MRA)	.....	.....	.....	.....	.....
74190	X	X-ray exam of peritoneum	706	1.96	$103.82	$57.63	$20.76
74210	S	Contrast xray exam of throat	736	1.85	$97.95	$54.24	$19.59
74220	S	Contrast xray exam,esophagus	736	1.85	$97.95	$54.24	$19.59
74230	S	Cinema xray throat/esophagus	736	1.85	$97.95	$54.24	$19.59
74235	S	Remove esophagus obstruction	738	4.48	$237.03	$133.34	$47.41
74240	S	X-ray exam upper GI tract	736	1.85	$97.95	$54.24	$19.59
74241	S	X-ray exam upper GI tract	736	1.85	$97.95	$54.24	$19.59
74245	S	X-ray exam upper GI tract	736	1.85	$97.95	$54.24	$19.59
74246	S	Contrast xray upper GI tract	736	1.85	$97.95	$54.24	$19.59
74247	S	Contrast xray upper GI tract	736	1.85	$97.95	$54.24	$19.59
74249	S	Contrast xray upper GI tract	736	1.85	$97.95	$54.24	$19.59
74250	S	X-ray exam of small bowel	736	1.85	$97.95	$54.24	$19.59
74251	S	X-ray exam of small bowel	736	1.85	$97.95	$54.24	$19.59
74260	S	X-ray exam of small bowel	736	1.85	$97.95	$54.24	$19.59
74270	S	Contrast x-ray exam of colon	736	1.85	$97.95	$54.24	$19.59
74280	S	Contrast x-ray exam of colon	736	1.85	$97.95	$54.24	$19.59
74283	S	Contrast x-ray exam of colon	736	1.85	$97.95	$54.24	$19.59
74290	S	Contrast x-ray, gallbladder	736	1.85	$97.95	$54.24	$19.59
74291	S	Contrast x-rays, gallbladder	736	1.85	$97.95	$54.24	$19.59
74300	C	X-ray bile ducts, pancreas	.....	.....	.....	.....	.....
74301	C	Additional x-rays at surgery	.....	.....	.....	.....	.....
74305	X	X-ray bile ducts, pancreas	706	1.96	$103.82	$57.63	$20.76
74320	X	Contrast x-ray of bile ducts	706	1.96	$103.82	$57.63	$20.76
74327	S	X-ray for bile stone removal	738	4.48	$237.03	$133.34	$47.41

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
74328	X	Xray for bile duct endoscopy	706	1.96	$103.82	$57.63	$20.76
74329	X	X-ray for pancreas endoscopy	706	1.96	$103.82	$57.63	$20.76
74330	X	Xray,bile/pancreas endoscopy	706	1.96	$103.82	$57.63	$20.76
74340	X	X-ray guide for GI tube	716	1.59	$84.23	$47.91	$16.85
74350	X	X-ray guide, stomach tube	706	1.96	$103.82	$57.63	$20.76
74355	X	X-ray guide, intestinal tube	706	1.96	$103.82	$57.63	$20.76
74360	S	X-ray guide, GI dilation	738	4.48	$237.03	$133.34	$47.41
74363	S	X-ray, bile duct dilation	738	4.48	$237.03	$133.34	$47.41
74400	S	Contrast x-ray urinary tract	737	2.81	$148.88	$86.56	$29.78
74405	S	Contrast x-ray urinary tract	737	2.81	$148.88	$86.56	$29.78
74410	S	Contrast x-ray urinary tract	737	2.81	$148.88	$86.56	$29.78
74415	S	Contrast x-ray urinary tract	737	2.81	$148.88	$86.56	$29.78
74420	S	Contrast x-ray urinary tract	737	2.81	$148.88	$86.56	$29.78
74425	S	Contrast x-ray urinary tract	737	2.81	$148.88	$86.56	$29.78
74430	S	Contrast x-ray of bladder	737	2.81	$148.88	$86.56	$29.78
74440	S	Xray exam male genital tract	737	2.81	$148.88	$86.56	$29.78
74445	S	X-ray exam of penis	737	2.81	$148.88	$86.56	$29.78
74450	S	X-ray exam urethra/bladder	737	2.81	$148.88	$86.56	$29.78
74455	S	X-ray exam urethra/bladder	737	2.81	$148.88	$86.56	$29.78
74470	X	X-ray exam of kidney lesion	706	1.96	$103.82	$57.63	$20.76
74475	S	Xray control catheter insert	738	4.48	$237.03	$133.34	$47.41
74480	S	Xray control catheter insert	738	4.48	$237.03	$133.34	$47.41
74485	S	X-ray guide, GU dilation	738	4.48	$237.03	$133.34	$47.41
74710	X	X-ray measurement of pelvis	700	0.78	$41.14	$22.37	$8.23
74740	X	X-ray female genital tract	706	1.96	$103.82	$57.63	$20.76
74742	X	X-ray fallopian tube	706	1.96	$103.82	$57.63	$20.76
74775	S	X-ray exam of perineum	737	2.81	$148.88	$86.56	$29.78
75552	S	Magnetic image, myocardium	726	7.96	$421.16	$258.09	$84.23
75553	S	Magnetic image, myocardium	726	7.96	$421.16	$258.09	$84.23
75554	S	Cardiac MRI/function	726	7.96	$421.16	$258.09	$84.23
75555	S	Cardiac MRI/limited study	726	7.96	$421.16	$258.09	$84.23
75556	E	Cardiac MRI/flow mapping	.....	.....	.....	.....	.....
75600	S	Contrast x-ray exam of aorta	739	5.83	$308.53	$168.82	$61.71
75605	S	Contrast x-ray exam of aorta	739	5.83	$308.53	$168.82	$61.71
75625	S	Contrast x-ray exam of aorta	739	5.83	$308.53	$168.82	$61.71
75630	S	X-ray aorta, leg arteries	739	5.83	$308.53	$168.82	$61.71
75650	S	Artery x-rays, head & neck	739	5.83	$308.53	$168.82	$61.71
75658	S	X-ray exam of arm arteries	739	5.83	$308.53	$168.82	$61.71
75660	S	Artery x-rays, head & neck	739	5.83	$308.53	$168.82	$61.71
75662	S	Artery x-rays, head & neck	739	5.83	$308.53	$168.82	$61.71
75665	S	Artery x-rays, head & neck	739	5.83	$308.53	$168.82	$61.71
75671	S	Artery x-rays, head & neck	739	5.83	$308.53	$168.82	$61.71
75676	S	Artery x-rays, neck	739	5.83	$308.53	$168.82	$61.71
75680	S	Artery x-rays, neck	739	5.83	$308.53	$168.82	$61.71
75685	S	Artery x-rays, spine	739	5.83	$308.53	$168.82	$61.71
75705	S	Artery x-rays, spine	739	5.83	$308.53	$168.82	$61.71
75710	S	Artery x-rays, arm/leg	739	5.83	$308.53	$168.82	$61.71
75716	S	Artery x-rays, arms/legs	739	5.83	$308.53	$168.82	$61.71
75722	S	Artery x-rays, kidney	739	5.83	$308.53	$168.82	$61.71
75724	S	Artery x-rays, kidneys	739	5.83	$308.53	$168.82	$61.71
75726	S	Artery x-rays, abdomen	739	5.83	$308.53	$168.82	$61.71
75731	S	Artery x-rays, adrenal gland	739	5.83	$308.53	$168.82	$61.71
75733	S	Artery x-rays,adrenal glands	739	5.83	$308.53	$168.82	$61.71
75736	S	Artery x-rays, pelvis	739	5.83	$308.53	$168.82	$61.71
75741	S	Artery x-rays, lung	739	5.83	$308.53	$168.82	$61.71
75743	S	Artery x-rays, lungs	739	5.83	$308.53	$168.82	$61.71
75746	S	Artery x-rays, lung	739	5.83	$308.53	$168.82	$61.71
75756	S	Artery x-rays, chest	739	5.83	$308.53	$168.82	$61.71
75774	S	Artery x-ray, each vessel	739	5.83	$308.53	$168.82	$61.71
75790	S	Visualize A–V shunt	739	5.83	$308.53	$168.82	$61.71
75801	X	Lymph vessel x-ray, arm/leg	706	1.96	$103.82	$57.63	$20.76
75803	X	Lymph vessel x-ray,arms/legs	706	1.96	$103.82	$57.63	$20.76
75805	X	Lymph vessel x-ray, trunk	706	1.96	$103.82	$57.63	$20.76
75807	X	Lymph vessel x-ray, trunk	706	1.96	$103.82	$57.63	$20.76
75809	X	Nonvascular shunt, x-ray	706	1.96	$103.82	$57.63	$20.76
75810	S	Vein x-ray, spleen/liver	739	5.83	$308.53	$168.82	$61.71
75820	S	Vein x-ray, arm/leg	739	5.83	$308.53	$168.82	$61.71
75822	S	Vein x-ray, arms/legs	739	5.83	$308.53	$168.82	$61.71
75825	S	Vein x-ray, trunk	739	5.83	$308.53	$168.82	$61.71
75827	S	Vein x-ray, chest	739	5.83	$308.53	$168.82	$61.71
75831	S	Vein x-ray, kidney	739	5.83	$308.53	$168.82	$61.71
75833	S	Vein x-ray, kidneys	739	5.83	$308.53	$168.82	$61.71
75840	S	Vein x-ray, adrenal gland	739	5.83	$308.53	$168.82	$61.71
75842	S	Vein x-ray, adrenal glands	739	5.83	$308.53	$168.82	$61.71
75860	S	Vein x-ray, neck	739	5.83	$308.53	$168.82	$61.71

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
75870	S	Vein x-ray, skull	739	5.83	$308.53	$168.82	$61.71
75872	S	Vein x-ray, skull	739	5.83	$308.53	$168.82	$61.71
75880	S	Vein x-ray, eye socket	739	5.83	$308.53	$168.82	$61.71
75885	S	Vein x-ray, liver	739	5.83	$308.53	$168.82	$61.71
75887	S	Vein x-ray, liver	739	5.83	$308.53	$168.82	$61.71
75889	S	Vein x-ray, liver	739	5.83	$308.53	$168.82	$61.71
75891	S	Vein x-ray, liver	739	5.83	$308.53	$168.82	$61.71
75893	N	Venous sampling by catheter					
75894	C	Xrays, transcatheter therapy					
75896	C	Xrays, transcatheter therapy					
75898	X	Follow-up angiogram	706	1.96	$103.82	$57.63	$20.76
75900	C	Arterial catheter exchange					
75940	C	X-ray placement, vein filter					
75945	C	Intravascular us					
75946	C	Intravascular us					
75960	C	Transcatheter intro, stent					
75961	C	Retrieval, broken catheter					
75962	C	Repair arterial blockage					
75964	C	Repair artery blockage, each					
75966	C	Repair arterial blockage					
75968	C	Repair artery blockage, each					
75970	C	Vascular biopsy					
75978	C	Repair venous blockage					
75980	S	Contrast xray exam bile duct	738	4.48	$237.03	$133.34	$47.41
75982	S	Contrast xray exam bile duct	738	4.48	$237.03	$133.34	$47.41
75984	S	Xray control catheter change	738	4.48	$237.03	$133.34	$47.41
75989	X	Abscess drainage under x-ray	716	1.59	$84.23	$47.91	$16.85
75992	C	Atherectomy, x-ray exam					
75993	C	Atherectomy, x-ray exam					
75994	C	Atherectomy, x-ray exam					
75995	C	Atherectomy, x-ray exam					
75996	C	Atherectomy, x-ray exam					
76000	X	Fluoroscope examination	716	1.59	$84.23	$47.91	$16.85
76001	X	Fluoroscope exam, extensive	716	1.59	$84.23	$47.91	$16.85
76003	X	Needle localization by x-ray	716	1.59	$84.23	$47.91	$16.85
76010	X	X-ray, nose to rectum	700	0.78	$41.14	$22.37	$8.23
76020	X	X-rays for bone age	700	0.78	$41.14	$22.37	$8.23
76040	X	X-rays, bone evaluation	700	0.78	$41.14	$22.37	$8.23
76061	X	X-rays, bone survey	700	0.78	$41.14	$22.37	$8.23
76062	X	X-rays, bone survey	700	0.78	$41.14	$22.37	$8.23
76065	X	X-rays, bone evaluation	700	0.78	$41.14	$22.37	$8.23
76066	X	Joint(s) survey, single film	700	0.78	$41.14	$22.37	$8.23
76070	E	CT scan, bone density study					
76075	X	Dual energy x-ray study	706	1.96	$103.82	$57.63	$20.76
76076	X	Dual energy x-ray study	700	0.78	$41.14	$22.37	$8.23
76078	X	Photodensitometry	700	0.78	$41.14	$22.37	$8.23
76080	X	X-ray exam of fistula	706	1.96	$103.82	$57.63	$20.76
76086	X	X-ray of mammary duct	706	1.96	$103.82	$57.63	$20.76
76088	X	X-ray of mammary ducts	706	1.96	$103.82	$57.63	$20.76
76090	S	Mammogram, one breast	746	0.69	$36.24	$19.44	$7.25
76091	S	Mammogram, both breasts	746	0.69	$36.24	$19.44	$7.25
76092	A	Mammogram, screening					
76093	S	Magnetic image, breast	726	7.96	$421.16	$258.09	$84.23
76094	S	Magnetic image, both breasts	726	7.96	$421.16	$258.09	$84.23
76095	X	Stereotactic breast biopsy	706	1.96	$103.82	$57.63	$20.76
76096	X	X-ray of needle wire, breast	706	1.96	$103.82	$57.63	$20.76
76098	X	X-ray exam, breast specimen	700	0.78	$41.14	$22.37	$8.23
76100	X	X-ray exam of body section	700	0.78	$41.14	$22.37	$8.23
76101	X	Complex body section x-ray	706	1.96	$103.82	$57.63	$20.76
76102	X	Complex body section x-rays	706	1.96	$103.82	$57.63	$20.76
76120	X	Cinematic x-rays	700	0.78	$41.14	$22.37	$8.23
76125	X	Cinematic x-rays	700	0.78	$41.14	$22.37	$8.23
76140	E	X-ray consultation					
76150	X	X-ray exam, dry process	700	0.78	$41.14	$22.37	$8.23
76350	N	Special x-ray contrast study					
76355	S	CAT scan for localization	710	5.06	$267.39	$176.28	$53.48
76360	S	CAT scan for needle biopsy	710	5.06	$267.39	$176.28	$53.48
76365	S	CAT scan for cyst aspiration	710	5.06	$267.39	$176.28	$53.48
76370	S	CAT scan for therapy guide	710	5.06	$267.39	$176.28	$53.48
76375	S	3d/holograph reconstr add-on	710	5.06	$267.39	$176.28	$53.48
76380	S	CAT scan follow-up study	710	5.06	$267.39	$176.28	$53.48
76390	S	Mr spectroscopy	726	7.96	$421.16	$258.09	$84.23
76400	S	Magnetic image, bone marrow	726	7.96	$421.16	$258.09	$84.23
76499	X	Radiographic procedure	700	0.78	$41.14	$22.37	$8.23
76506	S	Echo exam of head	747	1.65	$87.17	$54.69	$17.43

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
76511	S	Echo exam of eye	747	1.65	$87.17	$54.69	$17.43
76512	S	Echo exam of eye	747	1.65	$87.17	$54.69	$17.43
76513	S	Echo exam of eye, water bath	747	1.65	$87.17	$54.69	$17.43
76516	S	Echo exam of eye	747	1.65	$87.17	$54.69	$17.43
76519	S	Echo exam of eye	747	1.65	$87.17	$54.69	$17.43
76529	S	Echo exam of eye	747	1.65	$87.17	$54.69	$17.43
76536	S	Echo exam of head and neck	747	1.65	$87.17	$54.69	$17.43
76604	S	Echo exam of chest	747	1.65	$87.17	$54.69	$17.43
76645	S	Echo exam of breast	747	1.65	$87.17	$54.69	$17.43
76700	S	Echo exam of abdomen	747	1.65	$87.17	$54.69	$17.43
76705	S	Echo exam of abdomen	747	1.65	$87.17	$54.69	$17.43
76770	S	Echo exam abdomen back wall	747	1.65	$87.17	$54.69	$17.43
76775	S	Echo exam abdomen back wall	747	1.65	$87.17	$54.69	$17.43
76778	S	Echo exam kidney transplant	747	1.65	$87.17	$54.69	$17.43
76800	S	Echo exam spinal canal	747	1.65	$87.17	$54.69	$17.43
76805	S	Echo exam of pregnant uterus	747	1.65	$87.17	$54.69	$17.43
76810	S	Echo exam of pregnant uterus	747	1.65	$87.17	$54.69	$17.43
76815	S	Echo exam of pregnant uterus	747	1.65	$87.17	$54.69	$17.43
76816	S	Echo exam followup or repeat	747	1.65	$87.17	$54.69	$17.43
76818	S	Fetal biophysical profile	747	1.65	$87.17	$54.69	$17.43
76825	X	Echo exam of fetal heart	957	2.83	$149.86	$117.07	$29.97
76826	X	Echo exam of fetal heart	957	2.83	$149.86	$117.07	$29.97
76827	X	Echo exam of fetal heart	957	2.83	$149.86	$117.07	$29.97
76828	X	Echo exam of fetal heart	957	2.83	$149.86	$117.07	$29.97
76830	S	Echo exam, transvaginal	747	1.65	$87.17	$54.69	$17.43
76831	S	Echo exam, uterus	747	1.65	$87.17	$54.69	$17.43
76856	S	Echo exam of pelvis	747	1.65	$87.17	$54.69	$17.43
76857	S	Echo exam of pelvis	747	1.65	$87.17	$54.69	$17.43
76870	S	Echo exam of scrotum	747	1.65	$87.17	$54.69	$17.43
76872	S	Echo exam, transrectal	747	1.65	$87.17	$54.69	$17.43
76880	S	Echo exam of extremity	747	1.65	$87.17	$54.69	$17.43
76885	S	Echo exam, infant hips	747	1.65	$87.17	$54.69	$17.43
76886	S	Echo exam, infant hips	747	1.65	$87.17	$54.69	$17.43
76930	X	Echo guide for heart sac tap	749	2.46	$130.27	$76.16	$26.05
76932	X	Echo guide for heart biopsy	749	2.46	$130.27	$76.16	$26.05
76934	X	Echo guide for chest tap	749	2.46	$130.27	$76.16	$26.05
76936	X	Echo guide for artery repair	749	2.46	$130.27	$76.16	$26.05
76938	X	Echo exam for drainage	749	2.46	$130.27	$76.16	$26.05
76941	X	Echo guide for transfusion	749	2.46	$130.27	$76.16	$26.05
76942	X	Echo guide for biopsy	749	2.46	$130.27	$76.16	$26.05
76945	X	Echo guide, villus sampling	749	2.46	$130.27	$76.16	$26.05
76946	X	Echo guide for amniocentesis	749	2.46	$130.27	$76.16	$26.05
76948	X	Echo guide, ova aspiration	749	2.46	$130.27	$76.16	$26.05
76950	X	Echo guidance radiotherapy	749	2.46	$130.27	$76.16	$26.05
76960	X	Echo guidance radiotherapy	749	2.46	$130.27	$76.16	$26.05
76965	X	Echo guidance radiotherapy	749	2.46	$130.27	$76.16	$26.05
76970	S	Ultrasound exam follow-up	747	1.65	$87.17	$54.69	$17.43
76975	S	GI endoscopic ultrasound	747	1.65	$87.17	$54.69	$17.43
76986	S	Echo exam at surgery	747	1.65	$87.17	$54.69	$17.43
76999	S	Echo examination procedure	747	1.65	$87.17	$54.69	$17.43
77261	X	Radiation therapy planning	750	0.93	$48.97	$25.54	$9.79
77262	X	Radiation therapy planning	750	0.93	$48.97	$25.54	$9.79
77263	X	Radiation therapy planning	750	0.93	$48.97	$25.54	$9.79
77280	X	Set radiation therapy field	752	3.56	$188.05	$88.82	$37.61
77285	X	Set radiation therapy field	752	3.56	$188.05	$88.82	$37.61
77290	X	Set radiation therapy field	752	3.56	$188.05	$88.82	$37.61
77295	X	Set radiation therapy field	752	3.56	$188.05	$88.82	$37.61
77299	X	Radiation therapy planning	751	1.07	$56.81	$33.22	$11.36
77300	X	Radiation therapy dose plan	751	1.07	$56.81	$33.22	$11.36
77305	X	Radiation therapy dose plan	751	1.07	$56.81	$33.22	$11.36
77310	X	Radiation therapy dose plan	751	1.07	$56.81	$33.22	$11.36
77315	X	Radiation therapy dose plan	751	1.07	$56.81	$33.22	$11.36
77321	X	Radiation therapy port plan	751	1.07	$56.81	$33.22	$11.36
77326	X	Radiation therapy dose plan	751	1.07	$56.81	$33.22	$11.36
77327	X	Radiation therapy dose plan	751	1.07	$56.81	$33.22	$11.36
77328	X	Radiation therapy dose plan	751	1.07	$56.81	$33.22	$11.36
77331	X	Special radiation dosimetry	751	1.07	$56.81	$33.22	$11.36
77332	X	Radiation treatment aid(s)	751	1.07	$56.81	$33.22	$11.36
77333	X	Radiation treatment aid(s)	751	1.07	$56.81	$33.22	$11.36
77334	X	Radiation treatment aid(s)	751	1.07	$56.81	$33.22	$11.36
77336	X	Radiation physics consu	750	0.93	$48.97	$25.54	$9.79
77370	X	Radiation physics consult	750	0.93	$48.97	$25.54	$9.79
77399	X	External radiation dosimetry	750	0.93	$48.97	$25.54	$9.79
77401	S	Radiation treatment delivery	757	2.20	$116.55	$52.43	$23.31
77402	S	Radiation treatment delivery	757	2.20	$116.55	$52.43	$23.31

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
77403	S	Radiation treatment delivery	757	2.20	$116.55	$52.43	$23.31
77404	S	Radiation treatment delivery	757	2.20	$116.55	$52.43	$23.31
77406	S	Radiation treatment delivery	757	2.20	$116.55	$52.43	$23.31
77407	S	Radiation treatment delivery	757	2.20	$116.55	$52.43	$23.31
77408	S	Radiation treatment delivery	757	2.20	$116.55	$52.43	$23.31
77409	S	Radiation treatment delivery	757	2.20	$116.55	$52.43	$23.31
77411	S	Radiation treatment delivery	757	2.20	$116.55	$52.43	$23.31
77412	S	Radiation treatment delivery	757	2.20	$116.55	$52.43	$23.31
77413	S	Radiation treatment delivery	757	2.20	$116.55	$52.43	$23.31
77414	S	Radiation treatment delivery	757	2.20	$116.55	$52.43	$23.31
77416	S	Radiation treatment delivery	757	2.20	$116.55	$52.43	$23.31
77417	X	Radiology port film(s)	700	0.78	$41.14	$22.37	$8.23
77419	E	Weekly radiation therapy	.....	.....	.....	.....	.....
77420	E	Weekly radiation therapy	.....	.....	.....	.....	.....
77425	E	Weekly radiation therapy	.....	.....	.....	.....	.....
77430	E	Weekly radiation therapy	.....	.....	.....	.....	.....
77431	X	Radiation therapy management	750	0.93	$48.97	$25.54	$9.79
77432	X	Stereotactic radiation trmt	750	0.93	$48.97	$25.54	$9.79
77470	S	Special radiation treatment	757	2.20	$116.55	$52.43	$23.31
77499	N	Radiation therapy management	.....	.....	.....	.....	.....
77600	S	Hyperthermia treatment	758	3.41	$180.22	$76.84	$36.04
77605	S	Hyperthermia treatment	758	3.41	$180.22	$76.84	$36.04
77610	S	Hyperthermia treatment	758	3.41	$180.22	$76.84	$36.04
77615	S	Hyperthermia treatment	758	3.41	$180.22	$76.84	$36.04
77620	S	Hyperthermia treatment	758	3.41	$180.22	$76.84	$36.04
77750	S	Infuse radioactive materials	759	8.09	$428.02	$160.01	$85.60
77761	S	Radioelement application	759	8.09	$428.02	$160.01	$85.60
77762	S	Radioelement application	759	8.09	$428.02	$160.01	$85.60
77763	S	Radioelement application	759	8.09	$428.02	$160.01	$85.60
77776	S	Radioelement application	759	8.09	$428.02	$160.01	$85.60
77777	S	Radioelement application	759	8.09	$428.02	$160.01	$85.60
77778	S	Radioelement application	759	8.09	$428.02	$160.01	$85.60
77781	S	High intensity brachytherapy	759	8.09	$428.02	$160.01	$85.60
77782	S	High intensity brachytherapy	759	8.09	$428.02	$160.01	$85.60
77783	S	High intensity brachytherapy	759	8.09	$428.02	$160.01	$85.60
77784	S	High intensity brachytherapy	759	8.09	$428.02	$160.01	$85.60
77789	S	Radioelement application	759	8.09	$428.02	$160.01	$85.60
77790	N	Radioelement handling	.....	.....	.....	.....	.....
77799	S	Radium/radioisotope therapy	759	8.09	$428.02	$160.01	$85.60
78000	S	Thyroid, single uptake	761	2.06	$108.72	$61.47	$21.74
78001	S	Thyroid, multiple uptakes	762	1.80	$95.01	$51.53	$19.00
78003	S	Thyroid suppress/stimul	762	1.80	$95.01	$51.53	$19.00
78006	S	Thyroid, imaging with uptake	771	3.81	$201.77	$116.84	$40.35
78007	S	Thyroid, image, mult uptakes	772	4.28	$226.25	$127.92	$45.25
78010	S	Thyroid imaging	771	3.81	$201.77	$116.84	$40.35
78011	S	Thyroid imaging with flow	771	3.81	$201.77	$116.84	$40.35
78015	S	Thyroid met imaging	771	3.81	$201.77	$116.84	$40.35
78016	S	Thyroid met imaging/studies	772	4.28	$226.25	$127.92	$45.25
78017	S	Thyroid met imaging, mult	772	4.28	$226.25	$127.92	$45.25
78018	S	Thyroid, met imaging, body	772	4.28	$226.25	$127.92	$45.25
78070	S	Parathyroid nuclear imaging	772	4.28	$226.25	$127.92	$45.25
78075	S	Adrenal nuclear imaging	772	4.28	$226.25	$127.92	$45.25
78099	S	Endocrine nuclear procedure	761	2.06	$108.72	$61.47	$21.74
78102	S	Bone marrow imaging, ltd	771	3.81	$201.77	$116.84	$40.35
78103	S	Bone marrow imaging, mult	771	3.81	$201.77	$116.84	$40.35
78104	S	Bone marrow imaging, body	771	3.81	$201.77	$116.84	$40.35
78110	S	Plasma volume, single	761	2.06	$108.72	$61.47	$21.74
78111	S	Plasma volume, multiple	761	2.06	$108.72	$61.47	$21.74
78120	S	Red cell mass, single	761	2.06	$108.72	$61.47	$21.74
78121	S	Red cell mass, multiple	762	1.80	$95.01	$51.53	$19.00
78122	S	Blood volume	762	1.80	$95.01	$51.53	$19.00
78130	S	Red cell survival study	762	1.80	$95.01	$51.53	$19.00
78135	S	Red cell survival kinetics	762	1.80	$95.01	$51.53	$19.00
78140	S	Red cell sequestration	762	1.80	$95.01	$51.53	$19.00
78160	S	Plasma iron turnover	762	1.80	$95.01	$51.53	$19.00
78162	S	Iron absorption exam	762	1.80	$95.01	$51.53	$19.00
78170	S	Red cell iron utilization	762	1.80	$95.01	$51.53	$19.00
78172	S	Total body iron estimation	762	1.80	$95.01	$51.53	$19.00
78185	S	Spleen imaging	771	3.81	$201.77	$116.84	$40.35
78190	S	Platelet survival, kinetics	762	1.80	$95.01	$51.53	$19.00
78191	S	Platelet survival	762	1.80	$95.01	$51.53	$19.00
78195	S	Lymph system imaging	772	4.28	$226.25	$127.92	$45.25
78199	S	Blood/lymph nuclear exam	761	2.06	$108.72	$61.47	$21.74
78201	S	Liver imaging	771	3.81	$201.77	$116.84	$40.35
78202	S	Liver imaging with flow	771	3.81	$201.77	$116.84	$40.35

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
78205	S	Liver imaging (3D)	781	5.37	$284.04	$145.77	$56.81
78215	S	Liver and spleen imaging	771	3.81	$201.77	$116.84	$40.35
78216	S	Liver & spleen image, flow	771	3.81	$201.77	$116.84	$40.35
78220	S	Liver function study	772	4.28	$226.25	$127.92	$45.25
78223	S	Hepatobiliary imaging	772	4.28	$226.25	$127.92	$45.25
78230	S	Salivary gland imaging	771	3.81	$201.77	$116.84	$40.35
78231	S	Serial salivary imaging	771	3.81	$201.77	$116.84	$40.35
78232	S	Salivary gland function exam	772	4.28	$226.25	$127.92	$45.25
78258	S	Esophageal motility study	772	4.28	$226.25	$127.92	$45.25
78261	S	Gastric mucosa imaging	771	3.81	$201.77	$116.84	$40.35
78262	S	Gastroesophageal reflux exam	772	4.28	$226.25	$127.92	$45.25
78264	S	Gastric emptying study	772	4.28	$226.25	$127.92	$45.25
78270	S	Vit B–12 absorption exam	761	2.06	$108.72	$61.47	$21.74
78271	S	Vit B–12 absorp exam, IF	761	2.06	$108.72	$61.47	$21.74
78272	S	Vit B–12 absorp, combined	761	2.06	$108.72	$61.47	$21.74
78278	S	Acute GI blood loss imaging	772	4.28	$226.25	$127.92	$45.25
78282	S	GI protein loss exam	761	2.06	$108.72	$61.47	$21.74
78290	S	Meckel's divert exam	771	3.81	$201.77	$116.84	$40.35
78291	S	Leveen/shunt patency exam	772	4.28	$226.25	$127.92	$45.25
78299	S	GI nuclear procedure	761	2.06	$108.72	$61.47	$21.74
78300	S	Bone imaging, limited area	771	3.81	$201.77	$116.84	$40.35
78305	S	Bone imaging, multiple areas	771	3.81	$201.77	$116.84	$40.35
78306	S	Bone imaging, whole body	771	3.81	$201.77	$116.84	$40.35
78315	S	Bone imaging, 3 phase	772	4.28	$226.25	$127.92	$45.25
78320	S	Bone imaging (3D)	781	5.37	$284.04	$145.77	$56.81
78350	X	Bone mineral, single photon	700	0.78	$41.14	$22.37	$8.23
78351	E	Bone mineral, dual photon	.....	.....	.....	.....	.....
78399	S	Musculoskeletal nuclear exam	771	3.81	$201.77	$116.84	$40.35
78414	S	Non-imaging heart function	762	1.80	$95.01	$51.53	$19.00
78428	S	Cardiac shunt imaging	771	3.81	$201.77	$116.84	$40.35
78445	S	Vascular flow imaging	771	3.81	$201.77	$116.84	$40.35
78455	S	Venous thrombosis study	762	1.80	$95.01	$51.53	$19.00
78457	S	Venous thrombosis imaging	771	3.81	$201.77	$116.84	$40.35
78458	S	Ven thrombosis images, bilat	771	3.81	$201.77	$116.84	$40.35
78459	S	Heart muscle imaging (PET)	760	17.91	$947.13	$419.46	$189.43
78460	S	Heart muscle blood single	771	3.81	$201.77	$116.84	$40.35
78461	S	Heart muscle blood multiple	772	4.28	$226.25	$127.92	$45.25
78464	S	Heart image (3D) single	781	5.37	$284.04	$145.77	$56.81
78465	S	Heart image (3D) multiple	782	9.50	$502.46	$275.04	$100.49
78466	S	Heart infarct image	771	3.81	$201.77	$116.84	$40.35
78468	S	Heart infarct image, EF	772	4.28	$226.25	$127.92	$45.25
78469	S	Heart infarct image (3D)	781	5.37	$284.04	$145.77	$56.81
78472	S	Gated heart, resting	772	4.28	$226.25	$127.92	$45.25
78473	S	Gated heart, multiple	772	4.28	$226.25	$127.92	$45.25
78478	S	Heart wall motion (add-on)	771	3.81	$201.77	$116.84	$40.35
78480	S	Heart function, (add-on)	771	3.81	$201.77	$116.84	$40.35
78481	S	Heart first pass single	771	3.81	$201.77	$116.84	$40.35
78483	S	Heart first pass multiple	772	4.28	$226.25	$127.92	$45.25
78491	E	Heart image (pet) single	.....	.....	.....	.....	.....
78492	E	Heart image (pet) multiple	.....	.....	.....	.....	.....
78499	S	Cardiovascular nuclear exam	762	1.80	$95.01	$51.53	$19.00
78580	S	Lung perfusion imaging	771	3.81	$201.77	$116.84	$40.35
78584	S	Lung V/Q image single breath	772	4.28	$226.25	$127.92	$45.25
78585	S	Lung V/Q imaging	772	4.28	$226.25	$127.92	$45.25
78586	S	Aerosol lung image, single	771	3.81	$201.77	$116.84	$40.35
78587	S	Aerosol lung image, multiple	771	3.81	$201.77	$116.84	$40.35
78591	S	Vent image, 1 breath, 1 proj	771	3.81	$201.77	$116.84	$40.35
78593	S	Vent image, 1 proj, gas	771	3.81	$201.77	$116.84	$40.35
78594	S	Vent image, mult proj, gas	772	4.28	$226.25	$127.92	$45.25
78596	S	Lung differential function	772	4.28	$226.25	$127.92	$45.25
78599	S	Respiratory nuclear exam	771	3.81	$201.77	$116.84	$40.35
78600	S	Brain imaging, ltd static	771	3.81	$201.77	$116.84	$40.35
78601	S	Brain ltd imaging & flow	771	3.81	$201.77	$116.84	$40.35
78605	S	Brain imaging, complete	771	3.81	$201.77	$116.84	$40.35
78606	S	Brain imaging comp & flow	772	4.28	$226.25	$127.92	$45.25
78607	S	Brain imaging (3D)	781	5.37	$284.04	$145.77	$56.81
78608	S	Brain imaging (PET)	760	17.91	$947.13	$419.46	$189.43
78609	S	Brain imaging (PET)	760	17.91	$947.13	$419.46	$189.43
78610	S	Brain flow imaging only	771	3.81	$201.77	$116.84	$40.35
78615	S	Cerebral blood flow imaging	772	4.28	$226.25	$127.92	$45.25
78630	S	Cerebrospinal fluid scan	772	4.28	$226.25	$127.92	$45.25
78635	S	CSF ventriculography	772	4.28	$226.25	$127.92	$45.25
78645	S	CSF shunt evaluation	772	4.28	$226.25	$127.92	$45.25
78647	S	Cerebrospinal fluid scan	781	5.37	$284.04	$145.77	$56.81
78650	S	CSF leakage imaging	772	4.28	$226.25	$127.92	$45.25

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
78660	S	Nuclear exam of tear flow	771	3.81	$201.77	$116.84	$40.35
78699	S	Nervous system nuclear exam	771	3.81	$201.77	$116.84	$40.35
78700	S	Kidney imaging, static	771	3.81	$201.77	$116.84	$40.35
78701	S	Kidney imaging with flow	771	3.81	$201.77	$116.84	$40.35
78704	S	Imaging renogram	771	3.81	$201.77	$116.84	$40.35
78707	S	Kidney flow & function image	771	3.81	$201.77	$116.84	$40.35
78708	S	Kidney flow & function image	772	4.28	$226.25	$127.92	$45.25
78709	S	Kidney flow & function image	772	4.28	$226.25	$127.92	$45.25
78710	S	Kidney imaging (3D)	781	5.37	$284.04	$145.77	$56.81
78715	S	Renal vascular flow exam	771	3.81	$201.77	$116.84	$40.35
78725	S	Kidney function study	761	2.06	$108.72	$61.47	$21.74
78730	S	Urinary bladder retention	771	3.81	$201.77	$116.84	$40.35
78740	S	Ureteral reflux study	772	4.28	$226.25	$127.92	$45.25
78760	S	Testicular imaging	771	3.81	$201.77	$116.84	$40.35
78761	S	Testicular imaging & flow	771	3.81	$201.77	$116.84	$40.35
78799	S	Genitourinary nuclear exam	771	3.81	$201.77	$116.84	$40.35
78800	S	Tumor imaging, limited area	772	4.28	$226.25	$127.92	$45.25
78801	S	Tumor imaging, mult areas	772	4.28	$226.25	$127.92	$45.25
78802	S	Tumor imaging, whole body	772	4.28	$226.25	$127.92	$45.25
78803	S	Tumor imaging (3D)	782	9.50	$502.46	$275.04	$100.49
78805	S	Abscess imaging, ltd area	772	4.28	$226.25	$127.92	$45.25
78806	S	Abscess imaging, whole body	772	4.28	$226.25	$127.92	$45.25
78807	S	Nuclear localization/abscess	782	9.50	$502.46	$275.04	$100.49
78810	S	Tumor imaging (PET)	760	17.91	$947.13	$419.46	$189.43
78890	N	Nuclear medicine data proc					
78891	N	Nuclear med data proc					
78990	E	Provide diag radionuclide(s)					
78999	S	Nuclear diagnostic exam	761	2.06	$108.72	$61.47	$21.74
79000	S	Intial hyperthyroid therapy	792	4.80	$253.68	$144.19	$50.74
79001	S	Repeat hyperthyroid therapy	791	16.26	$859.96	$562.06	$171.99
79020	S	Thyroid ablation	792	4.80	$253.68	$144.19	$50.74
79030	S	Thyroid ablation, carcinoma	792	4.80	$253.68	$144.19	$50.74
79035	S	Thyroid metastatic therapy	792	4.80	$253.68	$144.19	$50.74
79100	S	Hematopoetic nuclear therapy	791	16.26	$859.96	$562.06	$171.99
79200	S	Intracavitary nuc treatment	792	4.80	$253.68	$144.19	$50.74
79300	S	Interstitial nuclear therapy	791	16.26	$859.96	$562.06	$171.99
79400	S	Nonhemato nuclear therapy	791	16.26	$859.96	$562.06	$171.99
79420	S	Intravascular nuc therapy	791	16.26	$859.96	$562.06	$171.99
79440	S	Nuclear joint therapy	791	16.26	$859.96	$562.06	$171.99
79900	N	Provide ther radiopharm(s)					
79999	S	Nuclear medicine therapy	791	16.26	$859.96	$562.06	$171.99
80049	A	Metabolic panel, basic					
80050	A	General health panel					
80051	A	Electrolyte panel					
80054	A	Comprehen metabolic panel					
80055	A	Obstetric panel					
80058	A	Hepatic function panel					
80059	A	Hepatitis panel					
80061	A	Lipid panel					
80072	A	Arthritis panel					
80090	A	Torch antibody panel					
80091	A	Thyroid panel					
80092	A	Thyroid panel w/TSH					
80100	A	Drug screen					
80101	A	Drug screen					
80102	A	Drug confirmation					
80103	N	Drug analysis, tissue prep					
80150	A	Assay of amikacin					
80152	A	Assay of amitriptyline					
80154	A	Assay of benzodiazepines					
80156	A	Assay carbamazepine					
80158	A	Assay of cyclosporine					
80160	A	Assay of desipramine					
80162	A	Assay for digoxin					
80164	A	Assay, dipropylacetic acid					
80166	A	Assay of doxepin					
80168	A	Assay of ethosuximide					
80170	A	Gentamicin					
80172	A	Assay for gold					
80174	A	Assay of imipramine					
80176	A	Assay for lidocaine					
80178	A	Assay for lithium					
80182	A	Assay for nortriptyline					
80184	A	Assay for phenobarbital					
80185	A	Assay for phenytoin					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
80186	A	Assay for phenytoin, free					
80188	A	Assay for primidone					
80190	A	Assay for procainamide					
80192	A	Assay for procainamide					
80194	A	Assay for quinidine					
80196	A	Assay for salicylate					
80197	A	Assay for tacrolimus					
80198	A	Assay for theophylline					
80200	A	Assay for tobramycin					
80201	A	Assay for topiramate					
80202	A	Assay for vancomycin					
80299	A	Quantitative assay, drug					
80400	A	Acth stimulation panel					
80402	A	Acth stimulation panel					
80406	A	Acth stimulation panel					
80408	A	Aldosterone suppression eval					
80410	A	Calcitonin stimul panel					
80412	A	CRH stimulation panel					
80414	A	Testosterone response					
80415	A	Estradiol response panel					
80416	A	Renin stimulation panel					
80417	A	Renin stimulation panel					
80418	A	Pituitary evaluation panel					
80420	A	Dexamethasone panel					
80422	A	Glucagon tolerance panel					
80424	A	Glucagon tolerance panel					
80426	A	Gonadotropin hormone panel					
80428	A	Growth hormone panel					
80430	A	Growth hormone panel					
80432	A	Insulin suppression panel					
80434	A	Insulin tolerance panel					
80435	A	Insulin tolerance panel					
80436	A	Metyrapone panel					
80438	A	TRH stimulation panel					
80439	A	TRH stimulation panel					
80440	A	TRH stimulation panel					
80500	X	Lab pathology consultation	882	0.39	$20.57	$11.75	$4.11
80502	X	Lab pathology consultation	882	0.39	$20.57	$11.75	$4.11
81000	A	Urinalysis, nonauto, w/scope					
81001	A	Urinalysis, auto, w/scope					
81002	A	Urinalysis nonauto w/o scope					
81003	A	Urinalysis, auto, w/o scope					
81005	A	Urinalysis					
81007	A	Urine screen for bacteria					
81015	A	Microscopic exam of urine					
81020	A	Urinalysis, glass test					
81025	A	Urine pregnancy test					
81050	A	Urinalysis, volume measure					
81099	A	Urinalysis test procedure					
82000	A	Assay blood acetaldehyde					
82003	A	Assay acetaminophen					
82009	A	Test for acetone/ketones					
82010	A	Acetone assay					
82013	A	Acetylcholinester- ase assay					
82024	A	ACTH					
82030	A	ADP & AMP					
82040	A	Assay serum albumin					
82042	A	Assay urine albumin					
82043	A	Microalbumin, quantitative					
82044	A	Microalbumin, semiquant					
82055	A	Assay ethanol					
82075	A	Assay breath ethanol					
82085	A	Assay of aldolase					
82088	A	Aldosterone					
82101	A	Assay of urine alkaloids					
82103	A	Alpha-1-antitrypsin, total					
82104	A	Alpha-1-antitrypsin, pheno					
82105	A	Alpha-fetoprotein, serum					
82106	A	Alpha-fetoprotein; amniotic					
82108	A	Assay, aluminum					
82128	A	Test for amino acids					
82130	A	Amino acids analysis					
82131	A	Amino acids					
82135	A	Assay, aminolevulinic acid					
82140	A	Assay of ammonia					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
82143	A	Amniotic fluid scan					
82145	A	Assay of amphetamines					
82150	A	Assay of amylase					
82154	A	Androstanediol glucuronide					
82157	A	Assay of androstenedione					
82160	A	Androsterone assay					
82163	A	Assay of angiotensin II					
82164	A	Angiotensin I enzyme test					
82172	A	Apolipoprotein					
82175	A	Assay of arsenic					
82180	A	Assay of ascorbic acid					
82190	A	Atomic absorption					
82205	A	Assay of barbiturates					
82232	A	Beta-2 protein					
82239	A	Bile acids, total					
82240	A	Bile acids, cholylglycine					
82250	A	Assay bilirubin					
82251	A	Assay bilirubin					
82252	A	Fecal bilirubin test					
82270	A	Test feces for blood					
82273	A	Test for blood, other source					
82286	A	Assay of bradykinin					
82300	A	Assay cadmium					
82306	A	Assay of vitamin D					
82307	A	Assay of vitamin D					
82308	A	Assay of calcitonin					
82310	A	Assay calcium					
82330	A	Assay calcium					
82331	A	Calcium infusion test					
82340	A	Assay calcium in urine					
82355	A	Calculus (stone) analysis					
82360	A	Calculus (stone) assay					
82365	A	Calculus (stone) assay					
82370	A	X-ray assay, calculus (stone)					
82374	A	Assay blood carbon dioxide					
82375	A	Assay blood carbon monoxide					
82376	A	Test for carbon monoxide					
82378	A	Carcinoembryonic antigen					
82380	A	Assay carotene					
82382	A	Assay urine catecholamines					
82383	A	Assay blood catecholamines					
82384	A	Assay three catecholamines					
82387	A	Cathepsin-D					
82390	A	Assay ceruloplasmin					
82397	A	Chemiluminescent assay					
82415	A	Assay chloramphenicol					
82435	A	Assay blood chloride					
82436	A	Assay urine chloride					
82438	A	Assay other fluid chlorides					
82441	A	Test for chlorohydrocarbons					
82465	A	Assay serum cholesterol					
82480	A	Assay serum cholinesterase					
82482	A	Assay rbc cholinesterase					
82485	A	Assay chondroitin sulfate					
82486	A	Gas/liquid chromatography					
82487	A	Paper chromatography					
82488	A	Paper chromatography					
82489	A	Thin layer chromatography					
82491	A	Chromotography, quantitative					
82495	A	Assay chromium					
82507	A	Assay citrate					
82520	A	Assay for cocaine					
82523	A	Collagen crosslinks					
82525	A	Assay copper					
82528	A	Assay corticosterone					
82530	A	Cortisol, free					
82533	A	Total cortisol					
82540	A	Assay creatine					
82550	A	Assay CK (CPK)					
82552	A	Assay CPK in blood					
82553	A	Creatine, MB fraction					
82554	A	Creatine, isoforms					
82565	A	Assay creatinine					
82570	A	Assay urine creatinine					
82575	A	Creatinine clearance test					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
82585	A	Assay cryofibrinogen					
82595	A	Assay cryoglobulin					
82600	A	Assay cyanide					
82607	A	Vitamin B–12					
82608	A	B–12 binding capacity					
82615	A	Test for urine cystines					
82626	A	Dehydroepiandrosterone					
82627	A	Dehydroepiandrosterone					
82633	A	Desoxycorticoster one					
82634	A	Deoxycortisol					
82638	A	Assay dibucaine number					
82646	A	Assay of dihydrocodeinone					
82649	A	Assay of dihydromorphin one					
82651	A	Dihydrotestosterone assay					
82652	A	Assay, dihydroxyvitamin D					
82654	A	Assay of dimethadione					
82664	A	Electrophoretic test					
82666	A	Epiandrosterone assay					
82668	A	Erythropoietin					
82670	A	Estradiol					
82671	A	Estrogens assay					
82672	A	Estrogen assay					
82677	A	Estriol					
82679	A	Estrone					
82690	A	Ethchlorvynol					
82693	A	Ethylene glycol					
82696	A	Etiocholanolone					
82705	A	Fats/lipids, feces, qualitative					
82710	A	Fats/lipids, feces, quantitative					
82715	A	Fecal fat assay					
82725	A	Assay blood fatty acids					
82728	A	Assay ferritin					
82735	A	Assay fluoride					
82742	A	Assay of flurazepam					
82746	A	Blood folic acid serum					
82747	A	Folic acid, RBC					
82757	A	Assay semen fructose					
82759	A	RBC galactokinase assay					
82760	A	Assay galactose					
82775	A	Assay galactose transferase					
82776	A	Galactose transferase test					
82784	A	Assay gammaglobulin IgM					
82785	A	Assay, gammaglobulin IgE					
82787	A	IgG1, 2, 3 and 4					
82800	A	Blood pH					
82803	A	Blood gases: pH, pO2 & pCO2					
82805	A	Blood gases W/02 saturation					
82810	A	Blood gases, O2 sat only					
82820	A	Hemoglobin-oxygen affinity					
82926	A	Assay gastric acid					
82928	A	Assay gastric acid					
82938	A	Gastrin test					
82941	A	Assay of gastrin					
82943	A	Assay of glucagon					
82946	A	Glucagon tolerance test					
82947	A	Assay quantitative, glucose					
82948	A	Reagent strip/blood glucose					
82950	A	Glucose test					
82951	A	Glucose tolerance test (GTT)					
82952	A	GTT-added samples					
82953	A	Glucose-tolbutamide test					
82955	A	Assay G6PD enzyme					
82960	A	Test for G6PD enzyme					
82962	A	Glucose blood test					
82963	A	Glucosidase assay					
82965	A	Assay GDH enzyme					
82975	A	Assay glutamine					
82977	A	Assay of GGT					
82978	A	Glutathione assay					
82979	A	Assay RBC glutathione enzyme					
82980	A	Assay of glutethimide					
82985	A	Glycated protein					
83001	A	Gonadotropin (FSH)					
83002	A	Gonadotropin (LH)					
83003	A	Assay growth hormone (HGH)					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
83008	A	Assay guanosine					
83010	A	Quant assay haptoglobin					
83012	A	Assay haptoglobins					
83015	A	Heavy metal screen					
83018	A	Quantitative screen, metals					
83019	A	Breath isotope test					
83020	A	Assay hemoglobin					
83026	A	Hemoglobin, copper sulfate					
83030	A	Fetal hemoglobin assay					
83033	A	Fetal fecal hemoglobin assay					
83036	A	Glycated hemoglobin test					
83045	A	Blood methemoglobin test					
83050	A	Blood methemoglobin assay					
83051	A	Assay plasma hemoglobin					
83055	A	Blood sulfhemoglobin test					
83060	A	Blood sulfhemoglobin assay					
83065	A	Hemoglobin heat assay					
83068	A	Hemoglobin stability screen					
83069	A	Assay urine hemoglobin					
83070	A	Qualt assay hemosiderin					
83071	A	Quant assay of hemosiderin					
83088	A	Assay histamine					
83150	A	Assay for HVA					
83491	A	Assay of corticosteroids					
83497	A	Assay 5-HIAA					
83498	A	Assay of progesterone					
83499	A	Assay of progesterone					
83500	A	Assay free hydroxyproline					
83505	A	Assay total hydroxyproline					
83516	A	Immunoassay, non antibody					
83518	A	Immunoassay, dipstick					
83519	A	Immunoassay nonantibody					
83520	A	Immunoassay, RIA					
83525	A	Assay of insulin					
83527	A	Assay of insulin					
83528	A	Assay intrinsic factor					
83540	A	Assay iron					
83550	A	Iron binding test					
83570	A	Assay IDH enzyme					
83582	A	Assay ketogenic steroids					
83586	A	Assay 17–(17–KS)ketosteroids					
83593	A	Fractionation ketosteroids					
83605	A	Lactic acid assay					
83615	A	Lactate (LD) (LDH) enzyme					
83625	A	Assay LDH enzymes					
83632	A	Placental lactogen					
83633	A	Test urine for lactose					
83634	A	Assay urine for lactose					
83655	A	Assay for lead					
83661	A	Assay L/S ratio					
83662	A	L/S ratio, foam stability					
83670	A	Assay LAP enzyme					
83690	A	Assay lipase					
83715	A	Assay blood lipoproteins					
83717	A	Assay blood lipoproteins					
83718	A	Blood lipoprotein assay					
83719	A	Blood lipoprotein assay					
83721	A	Blood lipoprotein assay					
83727	A	LRH hormone assay					
83735	A	Assay magnesium					
83775	A	Assay of md enzyme					
83785	A	Assay of manganese					
83805	A	Assay of meprobamate					
83825	A	Assay mercury					
83835	A	Assay metanephrines					
83840	A	Assay methadone					
83857	A	Assay methemalbumin					
83858	A	Assay methsuximide					
83864	A	Mucopolysaccharides					
83866	A	Mucopolysaccharides screen					
83872	A	Assay synovial fluid mucin					
83873	A	Assay, CSF protein					
83874	A	Myoglobin					
83883	A	Nephelometry, not specified					
83885	A	Assay for nickel					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
83887	A	Assay nicotine					
83890	A	Molecular diagnostics					
83892	A	Molecular diagnostics					
83894	A	Molecular diagnostics					
83896	A	Molecular diagnostics					
83898	A	Molecular diagnostics					
83902	A	Molecular diagnostics					
83912	A	Genetic examination					
83915	A	Assay nucleotidase					
83916	A	Oligoclonal bands					
83918	A	Assay organic acids					
83925	A	Opiates					
83930	A	Assay blood osmolality					
83935	A	Assay urine osmolality					
83937	A	Assay for osteocalcin					
83945	A	Assay oxalate					
83970	A	Assay of parathormone					
83986	A	Assay body fluid acidity					
83992	A	Assay for phencyclidine					
84022	A	Assay of phenothiazine					
84030	A	Assay blood PKU					
84035	A	Assay phenylketones					
84060	A	Assay acid phosphatase					
84061	A	Phosphatase, forensic exam					
84066	A	Assay prostate phosphatase					
84075	A	Assay alkaline phosphatase					
84078	A	Assay alkaline phosphatase					
84080	A	Assay alkaline phosphatases					
84081	A	Amniotic fluid enzyme test					
84085	A	Assay RBC PG6D enzyme					
84087	A	Assay phosphohexose enzymes					
84100	A	Assay phosphorus					
84105	A	Assay urine phosphorus					
84106	A	Test for porphobilinogen					
84110	A	Assay porphobilinogen					
84119	A	Test urine for porphyrins					
84120	A	Assay urine porphyrins					
84126	A	Assay feces porphyrins					
84127	A	Porphyrins, feces					
84132	A	Assay serum potassium					
84133	A	Assay urine potassium					
84134	A	Prealbumin					
84135	A	Assay pregnanediol					
84138	A	Assay pregnanetriol					
84140	A	Assay for pregnenolone					
84143	A	Assay/17-hydroxypregnenolone					
84144	A	Assay progesterone					
84146	A	Assay for prolactin					
84150	A	Assay of prostaglandin					
84153	A	Prostate specific antigen					
84155	A	Assay protein					
84160	A	Assay serum protein					
84165	A	Assay serum proteins					
84181	A	Western blot test					
84182	A	Protein, western blot test					
84202	A	Assay RBC protoporphyrin					
84203	A	Test RBC protoporphyrin					
84206	A	Assay of proinsulin					
84207	A	Assay vitamin B–6					
84210	A	Assay pyruvate					
84220	A	Assay pyruvate kinase					
84228	A	Assay quinine					
84233	A	Assay estrogen					
84234	A	Assay progesterone					
84235	A	Assay endocrine hormone					
84238	A	Assay non-endocrine receptor					
84244	A	Assay of renin					
84252	A	Assay vitamin B–2					
84255	A	Assay selenium					
84260	A	Assay serotonin					
84270	A	Sex hormone globulin (SHBG)					
84275	A	Assay sialic acid					
84285	A	Assay silica					
84295	A	Assay serum sodium					
84300	A	Assay urine sodium					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
84305	A	Somatomedin					
84307	A	Somatostatin					
84311	A	Spectrophotometry					
84315	A	Body fluid specific gravity					
84375	A	Chromatogram assay, sugars					
84392	A	Assay urine sulfate					
84402	A	Testosterone					
84403	A	Assay total testosterone					
84425	A	Assay vitamin B–1					
84430	A	Assay thiocyanate					
84432	A	Thyroglobulin					
84436	A	Assay, total thyroxine					
84437	A	Assay neonatal thyroxine					
84439	A	Assay, free thyroxine					
84442	A	Thyroid activity (TBG) assay					
84443	A	Assay thyroid stim hormone					
84445	A	Thyroid immunoglobulins TSI					
84446	A	Assay vitamin E					
84449	A	Assay for transcortin					
84450	A	Transferase (AST) (SGOT)					
84460	A	Alanine amino (ALT) (SGPT)					
84466	A	Transferrin					
84478	A	Assay triglycerides					
84479	A	Assay thyroid (t–3 or t–4)					
84480	A	Assay triiodothyronine (t–3)					
84481	A	Free assay (FT–3)					
84482	A	T3 reverse					
84484	A	Troponin, quant					
84485	A	Assay duodenal fluid trypsin					
84488	A	Test feces for trypsin					
84490	A	Assay feces for trypsin					
84510	A	Assay tyrosine					
84512	A	Troponin, qual					
84520	A	Assay urea nitrogen					
84525	A	Urea nitrogen semi-quant					
84540	A	Assay urine urea-N					
84545	A	Urea-N clearance test					
84550	A	Assay blood uric acid					
84560	A	Assay urine uric acid					
84577	A	Assay feces urobilinogen					
84578	A	Test urine urobilinogen					
84580	A	Assay urine urobilinogen					
84583	A	Assay urine urobilinogen					
84585	A	Assay urine VMA					
84586	A	VIP assay					
84588	A	Assay vasopressin					
84590	A	Assay vitamin-A					
84597	A	Assay vitamin-K					
84600	A	Assay for volatiles					
84620	A	Xylose tolerance test					
84630	A	Assay zinc					
84681	A	Assay C-peptide					
84702	A	Chorionic gonadotropin test					
84703	A	Chorionic gonadotropin assay					
84830	A	Ovulation tests					
84999	A	Clinical chemistry test					
85002	A	Bleeding time test					
85007	A	Differential WBC count					
85008	A	Nondifferential WBC count					
85009	A	Differential WBC count					
85013	A	Hematocrit					
85014	A	Hematocrit					
85018	A	Hemoglobin					
85021	A	Automated hemogram					
85022	A	Automated hemogram					
85023	A	Automated hemogram					
85024	A	Automated hemogram					
85025	A	Automated hemogram					
85027	A	Automated hemogram					
85029	A	Automated hemogram					
85030	A	Automated hemogram					
85031	A	Manual hemogram, complete cbc					
85041	A	Red blood cell (RBC) count					
85044	A	Reticulocyte count					
85045	A	Reticulocyte count					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
85048	A	White blood cell (WBC) count					
85060	X	Blood smear interpretation	882	0.39	$20.57	$11.75	$4.11
85095	T	Bone marrow aspiration	121	0.67	$35.26	$21.02	$7.05
85097	X	Bone marrow interpretation	882	0.39	$20.57	$11.75	$4.11
85102	T	Bone marrow biopsy	121	0.67	$35.26	$21.02	$7.05
85130	A	Chromogenic substrate assay					
85170	A	Blood clot retraction					
85175	A	Blood clot lysis time					
85210	A	Blood clot factor II test					
85220	A	Blood clot factor V test					
85230	A	Blood clot factor VII test					
85240	A	Blood clot factor VIII test					
85244	A	Blood clot factor VIII test					
85245	A	Blood clot factor VIII test					
85246	A	Blood clot factor VIII test					
85247	A	Blood clot factor VIII test					
85250	A	Blood clot factor IX test					
85260	A	Blood clot factor X test					
85270	A	Blood clot factor XI test					
85280	A	Blood clot factor XII test					
85290	A	Blood clot factor XIII test					
85291	A	Blood clot factor XIII test					
85292	A	Blood clot factor assay					
85293	A	Blood clot factor assay					
85300	A	Antithrombin III test					
85301	A	Antithrombin III test					
85302	A	Blood clot inhibitor antigen					
85303	A	Blood clot inhibitor test					
85305	A	Blood clot inhibitor assay					
85306	A	Blood clot inhibitor test					
85335	A	Factor inhibitor test					
85337	A	Thrombomodulin					
85345	A	Coagulation time					
85347	A	Coagulation time					
85348	A	Coagulation time					
85360	A	Euglobulin lysis					
85362	A	Fibrin degradation products					
85366	A	Fibrinogen test					
85370	A	Fibrinogen test					
85378	A	Fibrin degradation					
85379	A	Fibrin degradation					
85384	A	Fibrinogen					
85385	A	Fibrinogen					
85390	A	Fibrinolysins screen					
85400	A	Fibrinolytic plasmin					
85410	A	Fibrinolytic antiplasmin					
85415	A	Fibrinolytic plasminogen					
85420	A	Fibrinolytic plasminogen					
85421	A	Fibrinolytic plasminogen					
85441	A	Heinz bodies; direct					
85445	A	Heinz bodies; induced					
85460	A	Hemoglobin, fetal					
85461	A	Hemoglobin, fetal					
85475	A	Hemolysin					
85520	A	Heparin assay					
85525	A	Heparin					
85530	A	Heparin-protamine tolerance					
85535	A	Iron stain, blood cells					
85540	A	Wbc alkaline phosphatase					
85547	A	RBC mechanical fragility					
85549	A	Muramidase					
85555	A	RBC osmotic fragility					
85557	A	RBC osmotic fragility					
85576	A	Blood platelet aggregation					
85585	A	Blood platelet estimation					
85590	A	Platelet manual count					
85595	A	Platelet count, automated					
85597	A	Platelet neutralization					
85610	A	Prothrombin time					
85611	A	Prothrombin test					
85612	A	Viper venom prothrombin time					
85613	A	Russell viper venom, diluted					
85635	A	Reptilase test					
85651	A	Rbc sed rate, nonauto					
85652	A	Rbc sed rate, auto					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
85660	A	RBC sickle cell test					
85670	A	Thrombin time, plasma					
85675	A	Thrombin time, titer					
85705	A	Thromboplastin inhibition					
85730	A	Thromboplastin time, partial					
85732	A	Thromboplastin time, partial					
85810	A	Blood viscosity examination					
85999	A	Hematology procedure					
86000	A	Agglutinins; febrile					
86003	A	Allergen specific IgE					
86005	A	Allergen specific IgE					
86021	A	WBC antibody identification					
86022	A	Platelet antibodies					
86023	A	Immunoglobulin assay					
86038	A	Antinuclear antibodies					
86039	A	Antinuclear antibodies (ANA)					
86060	A	Antistreptolysin O titer					
86063	A	Antistreptolysin O screen					
86077	X	Physician blood bank service	882	0.39	$20.57	$11.75	$4.11
86078	X	Physician blood bank service	882	0.39	$20.57	$11.75	$4.11
86079	X	Physician blood bank service	882	0.39	$20.57	$11.75	$4.11
86140	A	C-reactive protein					
86147	A	Cardiolipin antibody					
86148	A	Phospholipid antibody					
86155	A	Chemotaxis assay					
86156	A	Cold agglutinin screen					
86157	A	Cold agglutinin, titer					
86160	A	Complement, antigen					
86161	A	Complement/function activity					
86162	A	Complement, total (CH50)					
86171	A	Complement fixation, each					
86185	A	Counterimmunoelectrophoresis					
86215	A	Deoxyribonuclease, antibody					
86225	A	DNA antibody					
86226	A	DNA antibody, single strand					
86235	A	Nuclear antigen antibody					
86243	A	Fc receptor					
86255	A	Fluorescent antibody; screen					
86256	A	Fluorescent antibody; titer					
86277	A	Growth hormone antibody					
86280	A	Hemagglutination inhibition					
86308	A	Heterophile antibodies					
86309	A	Heterophile antibodies					
86310	A	Heterophile antibodies					
86316	A	Immunoassay, tumor antigen					
86317	A	Immunoassay, infectious agent					
86318	A	Immunoassay, infectious agent					
86320	A	Serum immunoelectrophoresis					
86325	A	Other immunoelectrophoresis					
86327	A	Immunoelectrophoresis assay					
86329	A	Immunodiffusion					
86331	A	Immunodiffusion ouchterlony					
86332	A	Immune complex assay					
86334	A	Immunofixation procedure					
86337	A	Insulin antibodies					
86340	A	Intrinsic factor antibody					
86341	A	Islet cell antibody					
86343	A	Leukocyte histamine release					
86344	A	Leukocyte phagocytosis					
86353	A	Lymphocyte transformation					
86359	A	T cells, total count					
86360	A	T cell absolute count/ratio					
86361	A	T cell absolute count					
86376	A	Microsomal antibody					
86378	A	Migration inhibitory factor					
86382	A	Neutralization test, viral					
86384	A	Nitroblue tetrazolium dye					
86403	A	Particle agglutination test					
86406	A	Particle agglutination test					
86430	A	Rheumatoid factor test					
86431	A	Rheumatoid factor, quant					
86485	X	Skin test, candida	861	0.13	$6.86	$3.62	$1.37
86490	X	Coccidioidomycosis skin test	861	0.13	$6.86	$3.62	$1.37
86510	X	Histoplasmosis skin test	861	0.13	$6.86	$3.62	$1.37
86580	X	TB intradermal test	861	0.13	$6.86	$3.62	$1.37

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
86585	X	TB tine test	861	0.13	$6.86	$3.62	$1.37
86586	X	Skin test, unlisted	861	0.13	$6.86	$3.62	$1.37
86588	A	Streptocollus, direct screen					
86590	A	Streptokinase, antibody					
86592	A	Blood serology, qualitative					
86593	A	Blood serology, quantitative					
86602	A	Antinomyces antibody					
86603	A	Adenovirus, antibody					
86606	A	Aspergillus antibody					
86609	A	Bacterium, antibody					
86612	A	Blastomyces, antibody					
86615	A	Bordetella antibody					
86617	A	Lyme disease antibody					
86618	A	Lyme disease antibody					
86619	A	Borrelia antibody					
86622	A	Brucella, antibody					
86625	A	Campylobacter, antibody					
86628	A	Candida, antibody					
86631	A	Chlamydia, antibody					
86632	A	Chlamydia, IgM, antibody					
86635	A	Coccidioides, antibody					
86638	A	Q fever antibody					
86641	A	Cryptococcus antibody					
86644	A	CMV antibody					
86645	A	CMV antibody, IgM					
86648	A	Diphtheria antibody					
86651	A	Encephalitis antibody					
86652	A	Encephalitis antibody					
86653	A	Encephalitis, antibody					
86654	A	Encephalitis, antibody					
86658	A	Enterovirus, antibody					
86663	A	Epstein-barr antibody					
86664	A	Epstein-barr antibody					
86665	A	Epstein-barr, antibody					
86668	A	Francisella tularensis					
86671	A	Fungus, antibody					
86674	A	Giardia lamblia					
86677	A	Helicobacter pylori					
86682	A	Helminth, antibody					
86684	A	Hemophilus influenza					
86687	A	HTLV I					
86688	A	HTLV–II					
86689	A	HTLV/HIV confirmatory test					
86692	A	Hepatitis, delta agent					
86694	A	Herpes simplex test					
86695	A	Herpes simplex test					
86698	A	Histoplasma					
86701	A	HIV–1					
86702	A	HIV–2					
86703	A	HIV–1/HIV–2, single assay					
86704	A	Hep b core ab test, igg & m					
86705	A	Hep b core ab test, igm					
86706	A	Hepatitis b surface ab test					
86707	A	Hepatitis be ab test					
86708	A	Hep a ab test, igg & m					
86709	A	Hep a ab test, igm					
86710	A	Influenza virus					
86713	A	Legionella					
86717	A	Leishmania					
86720	A	Leptospira					
86723	A	Listeria monocytogenes					
86727	A	Lymph choriomeningitis					
86729	A	Lympho venereum					
86732	A	Mucormycosis					
86735	A	Mumps					
86738	A	Mycoplasma					
86741	A	Neisseria meningitidis					
86744	A	Nocardia					
86747	A	Parvovirus					
86750	A	Malaria					
86753	A	Protozoa, not elsewhere					
86756	A	Respiratory virus					
86759	A	Rotavirus					
86762	A	Rubella					
86765	A	Rubeola					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
86768	A	Salmonella					
86771	A	Shigella					
86774	A	Tetanus					
86777	A	Toxoplasma					
86778	A	Toxoplasma, IgM					
86781	A	Treponema pallidum confirm					
86784	A	Trichinella					
86787	A	Varicella-zoster					
86790	A	Virus, not specified					
86793	A	Yersinia					
86800	A	Thyroglobulin antibody					
86803	A	Hepatitis c ab test					
86804	A	Hep c ab test, confirm					
86805	A	Lymphocytotoxicity assay					
86806	A	Lymphocytotoxicity assay					
86807	A	Cytotoxic antibody screening					
86808	A	Cytotoxic antibody screening					
86812	A	HLA typing, A, B, or C					
86813	A	HLA typing, A, B, or C					
86816	A	HLA typing, DR/DQ					
86817	A	HLA typing, DR/DQ					
86821	A	Lymphocyte culture, mixed					
86822	A	Lymphocyte culture, primed					
86849	A	Immunology procedure					
86850	A	RBC antibody screen					
86860	A	RBC antibody elution					
86870	A	RBC antibody identification					
86880	A	Coombs test					
86885	A	Coombs test					
86886	A	Coombs test					
86890	A	Autologous blood process					
86891	A	Autologous blood, op salvage					
86900	A	Blood typing, ABO					
86901	A	Blood typing, Rh (D)					
86903	A	Blood typing, antigen screen					
86904	A	Blood typing, patient serum					
86905	A	Blood typing, RBC antigens					
86906	A	Blood typing, Rh phenotype					
86910	E	Blood typing, paternity test					
86911	E	Blood typing, antigen system					
86915	A	Bone marrow					
86920	A	Compatibility test					
86921	A	Compatibility test					
86922	A	Compatibility test					
86927	A	Plasma, fresh frozen					
86930	A	Frozen blood prep					
86931	A	Frozen blood thaw					
86932	A	Frozen blood, freeze/thaw					
86940	A	Hemolysins/agglutinins auto					
86941	A	Hemolysins/agglutinins					
86945	A	Blood product/irradiation					
86950	A	Leukacyte transfusion					
86965	A	Pooling blood platelets					
86970	A	RBC pretreatment					
86971	A	RBC pretreatment					
86972	A	RBC pretreatment					
86975	A	RBC pretreatment, serum					
86976	A	RBC pretreatment, serum					
86977	A	RBC pretreatment, serum					
86978	A	RBC pretreatment, serum					
86985	A	Split blood or products					
86999	A	Transfusion procedure					
87001	A	Small animal inoculation					
87003	A	Small animal inoculation					
87015	A	Specimen concentration					
87040	A	Blood culture for bacteria					
87045	A	Stool culture for bacteria					
87060	A	Nose/throat culture,bacteria					
87070	A	Culture specimen, bacteria					
87072	A	Culture of specimen by kit					
87075	A	Culture specimen, bacteria					
87076	A	Bacteria identification					
87081	A	Bacteria culture screen					
87082	A	Culture of specimen by kit					
87083	A	Culture of specimen by kit					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
87084	A	Culture of specimen by kit					
87085	A	Culture of specimen by kit					
87086	A	Urine culture, colony count					
87087	A	Urine bacteria culture					
87088	A	Urine bacteria culture					
87101	A	Skin fungus culture					
87102	A	Fungus isolation culture					
87103	A	Blood fungus culture					
87106	A	Fungus identification					
87109	A	Mycoplasma culture					
87110	A	Culture, chlamydia					
87116	A	Mycobacteria culture					
87117	A	Mycobacteria culture					
87118	A	Mycobacteria identification					
87140	A	Culture typing, fluorescent					
87143	A	Culture typing, GLC method					
87145	A	Culture typing, phage method					
87147	A	Culture typing, serologic					
87151	A	Culture typing, serologic					
87155	A	Culture typing, precipitin					
87158	A	Culture typing, added method					
87163	A	Special microbiology culture					
87164	A	Dark field examination					
87166	A	Dark field examination					
87174	A	Endotoxin, bacterial					
87175	A	Assay, endotoxin, bacterial					
87176	A	Endotoxin, bacterial					
87177	A	Ova and parasites smears					
87181	A	Antibiotic sensitivity, each					
87184	A	Antibiotic sensitivity, each					
87186	A	Antibiotic sensitivity, MIC					
87187	A	Antibiotic sensitivity, MBC					
87188	A	Antibiotic sensitivity, each					
87190	A	TB antibiotic sensitivity					
87192	A	Antibiotic sensitivity, each					
87197	A	Bactericidal level, serum					
87205	A	Smear, stain & interpret					
87206	A	Smear, stain & interpret					
87207	A	Smear, stain & interpret					
87208	A	Smear, stain & interpret					
87210	A	Smear, stain & interpret					
87211	A	Smear, stain & interpret					
87220	A	Tissue exam for fungi					
87230	A	Assay, toxin or antitoxin					
87250	A	Virus inoculation for test					
87252	A	Virus inoculation for test					
87253	A	Virus inoculation for test					
87260	A	Adenovirus ag, dfa					
87265	A	Pertussis ag, dfa					
87270	A	Chylmd trach ag, dfa					
87272	A	Cryptosporidum ag, dfa					
87274	A	Herpes simplex ag, dfa					
87276	A	Influenza ag, dfa					
87278	A	Legion pneumo ag, dfa					
87280	A	Resp syncytial ag, dfa					
87285	A	Trepon pallidum ag, dfa					
87290	A	Varicella ag, dfa					
87299	A	Ag detection nos, dfa					
87301	A	Adenovirus ag, eia					
87320	A	Chylmd trach ag, eia					
87324	A	Clostridium ag, eia					
87328	A	Cryptospor ag, eia					
87332	A	Cytomegalovirus ag, eia					
87335	A	E coli 0157 ag, eia					
87340	A	Hepatitis b surface ag, eia					
87350	A	Hepatitis b ag, eia					
87380	A	Hepatitis delta ag, eia					
87385	A	Histoplasma capsul ag, eia					
87390	A	Hiv–1 ag, eia					
87391	A	Hiv–2 ag, eia					
87420	A	Resp syncytial ag, eia					
87425	A	Rotavirus ag, eia					
87430	A	Strep a ag, eia					
87449	A	Ag detect nos, eia, mult					
87450	A	Ag detect nos, eia, single					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
87470	A	Bartonella, dna, dir probe					
87471	A	Bartonella, dna, amp probe					
87472	A	Bartonella, dna, quant					
87475	A	Lyme dis, dna, dir probe					
87476	A	Lyme dis, dna, amp probe					
87477	A	Lyme dis, dna, quant					
87480	A	Candida, dna, dir probe					
87481	A	Candida, dna, amp probe					
87482	A	Candida, dna, quant					
87485	A	Chylmd pneum, dna, dir probe					
87486	A	Chylmd pneum, dna, amp probe					
87487	A	Chylmd pneum, dna, quant					
87490	A	Chylmd trach, dna, dir probe					
87491	A	Chylmd trach, dna, amp probe					
87492	A	Chylmd trach, dna, quant					
87495	A	Cytomeg, dna, dir probe					
87496	A	Cytomeg, dna, amp probe					
87497	A	Cytomeg, dna, quant					
87510	A	Gardner vag, dna, dir probe					
87511	A	Gardner vag, dna, amp probe					
87512	A	Gardner vag, dna, quant					
87515	A	Hepatitis b, dna, dir probe					
87516	A	Hepatitis b, dna, amp probe					
87517	A	Hepatitis b, dna, quant					
87520	A	Hepatitis c, rna, dir probe					
87521	A	Hepatitis c, rna, amp probe					
87522	A	Hepatitis c, rna, quant					
87525	A	Hepatitis g, dna, dir probe					
87526	A	Hepatitis g, dna, amp probe					
87527	A	Hepatitis g, dna, quant					
87528	A	Hsv, dna, dir probe					
87529	A	Hsv, dna, amp probe					
87530	A	Hsv, dna, quant					
87531	A	Hhv–6, dna, dir probe					
87532	A	Hhv–6, dna, amp probe					
87533	A	Hhv–6, dna, quant					
87534	A	Hiv–1, dna, dir probe					
87535	A	Hiv–1, dna, amp probe					
87536	A	Hiv–1, dna, quant					
87537	A	Hiv–2, dna, dir probe					
87538	A	Hiv–2, dna, amp probe					
87539	A	Hiv–2, dna, quant					
87540	A	Legion pneumo, dna, dir prob					
87541	A	Legion pneumo, dna, amp prob					
87542	A	Legion pneumo, dna, quant					
87550	A	Mycobacteria, dna, dir probe					
87551	A	Mycobacteria, dna, amp probe					
87552	A	Mycobacteria, dna, quant					
87555	A	M.tuberculo, dna, dir probe					
87556	A	M.tuberculo, dna, amp probe					
87557	A	M.tuberculo, dna, quant					
87560	A	M.avium-intra, dna, dir prob					
87561	A	M.avium-intra, dna, amp prob					
87562	A	M.avium-intra, dna, quant					
87580	A	M.pneumon, dna, dir probe					
87581	A	M.pneumon, dna, amp probe					
87582	A	M.pneumon, dna, quant					
87590	A	N.gonorrhoeae, dna, dir prob					
87591	A	N.gonorrhoeae, dna, amp prob					
87592	A	N.gonorrhoeae, dna, quant					
87620	A	Hpv, dna, dir probe					
87621	A	Hpv, dna, amp probe					
87622	A	Hpv, dna, quant					
87650	A	Strep a, dna, dir probe					
87651	A	Strep a, dna, amp probe					
87652	A	Strep a, dna, quant					
87797	A	Detect agent nos, dna, dir					
87798	A	Detect agent nos, dna, amp					
87799	A	Detect agent nos, dna, quant					
87810	A	Chylmd trach assay w/optic					
87850	A	N. gonorrhoeae assay w/optic					
87880	A	Strep a assay w/optic					
87899	A	Agent nos assay w/optic					
87999	A	Microbiology procedure					
88000	E	Autopsy (necropsy), gross					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
88005	E	Autopsy (necropsy), gross					
88007	E	Autopsy (necropsy), gross					
88012	E	Autopsy (necropsy), gross					
88014	E	Autopsy (necropsy), gross					
88016	E	Autopsy (necropsy), gross					
88020	E	Autopsy (necropsy), complete					
88025	E	Autopsy (necropsy), complete					
88027	E	Autopsy (necropsy), complete					
88028	E	Autopsy (necropsy), complete					
88029	E	Autopsy (necropsy), complete					
88036	E	Limited autopsy					
88037	E	Limited autopsy					
88040	E	Forensic autopsy (necropsy)					
88045	E	Coroner's autopsy (necropsy)					
88099	E	Necropsy (autopsy) procedure					
88104	X	Cytopathology, fluids	882	0.39	$20.57	$11.75	$4.11
88106	X	Cytopathology, fluids	882	0.39	$20.57	$11.75	$4.11
88107	X	Cytopathology, fluids	882	0.39	$20.57	$11.75	$4.11
88108	X	Cytopath, concentrate tech	882	0.39	$20.57	$11.75	$4.11
88125	X	Forensic cytopathology	881	0.20	$10.77	$6.78	$2.15
88130	A	Sex chromatin identification					
88140	A	Sex chromatin identification					
88141	N	Cytopath cerv/vag interpret					
88142	A	Cytopath cerv/vag thin layer					
88150	A	Cytopath cerv/vag					
88152	A	Cytopath cerv/vag auto					
88155	A	Cytopath cerv/vag index					
88156	A	Cytopath cerv/vag tbs					
88158	A	Cytopath cerv/vag tbs auto					
88160	X	Cytopath smear, other source	882	0.39	$20.57	$11.75	$4.11
88161	X	Cytopath smear, other source	882	0.39	$20.57	$11.75	$4.11
88162	X	Cytopath smear, other source	882	0.39	$20.57	$11.75	$4.11
88170	T	Fine needle aspiration	121	0.67	$35.26	$21.02	$7.05
88171	T	Fine needle aspiration	121	0.67	$35.26	$21.02	$7.05
88172	X	Evaluation of smear	882	0.39	$20.57	$11.75	$4.11
88173	X	Interpretation of smear	882	0.39	$20.57	$11.75	$4.11
88180	X	Cell marker study	882	0.39	$20.57	$11.75	$4.11
88182	X	Cell marker study	882	0.39	$20.57	$11.75	$4.11
88199	X	Cytopathology procedure	881	0.20	$10.77	$6.78	$2.15
88230	A	Tissue culture, lymphocyte					
88233	A	Tissue culture, skin/biopsy					
88235	A	Tissue culture, placenta					
88237	A	Tissue culture, bone marrow					
88239	A	Tissue culture, other					
88245	A	Chromosome analysis					
88248	A	Chromosome analysis					
88250	A	Chromosome analysis					
88260	A	Chromosome analysis: 5 cells					
88261	A	Chromosome analysis: 5 cells					
88262	A	Chromosome count:15–20 cells					
88263	A	Chromosome analysis:45 cells					
88267	A	Chromosome analysis:placenta					
88269	A	Chromosome analysis:amniotic					
88280	A	Chromosome karyotype study					
88283	A	Chromosome banding study					
88285	A	Chromosome count: additional					
88289	A	Chromosome study: additional					
88299	A	Cytogenetic study					
88300	X	Surg path, gross	881	0.20	$10.77	$6.78	$2.15
88302	X	Tissue exam by pathologist	882	0.39	$20.57	$11.75	$4.11
88304	X	Tissue exam by pathologist	882	0.39	$20.57	$11.75	$4.11
88305	X	Tissue exam by pathologist	882	0.39	$20.57	$11.75	$4.11
88307	X	Tissue exam by pathologist	883	0.65	$34.28	$20.34	$6.86
88309	X	Tissue exam by pathologist	883	0.65	$34.28	$20.34	$6.86
88311	X	Decalcify tissue	881	0.20	$10.77	$6.78	$2.15
88312	X	Special stains	882	0.39	$20.57	$11.75	$4.11
88313	X	Special stains	881	0.20	$10.77	$6.78	$2.15
88314	X	Histochemical stain	882	0.39	$20.57	$11.75	$4.11
88318	X	Chemical histochemistry	882	0.39	$20.57	$11.75	$4.11
88319	X	Enzyme histochemistry	882	0.39	$20.57	$11.75	$4.11
88321	X	Microslide consultation	882	0.39	$20.57	$11.75	$4.11
88323	X	Microslide consultation	882	0.39	$20.57	$11.75	$4.11
88325	X	Comprehensive review of data	882	0.39	$20.57	$11.75	$4.11
88329	X	Pathology consult in surgery	882	0.39	$20.57	$11.75	$4.11
88331	X	Pathology consult in surgery	882	0.39	$20.57	$11.75	$4.11

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
88332	X	Pathology consult in surgery	882	0.39	$20.57	$11.75	$4.11
88342	X	Immunocytochemistry	882	0.39	$20.57	$11.75	$4.11
88346	X	Immunofluorescent study	882	0.39	$20.57	$11.75	$4.11
88347	X	Immunofluorescent study	882	0.39	$20.57	$11.75	$4.11
88348	X	Electron microscopy	883	0.65	$34.28	$20.34	$6.86
88349	X	Scanning electron microscopy	883	0.65	$34.28	$20.34	$6.86
88355	X	Analysis, skeletal muscle	883	0.65	$34.28	$20.34	$6.86
88356	X	Analysis, nerve	883	0.65	$34.28	$20.34	$6.86
88358	X	Analysis, tumor	883	0.65	$34.28	$20.34	$6.86
88362	X	Nerve teasing preparations	883	0.65	$34.28	$20.34	$6.86
88365	X	Tissue hybridization	883	0.65	$34.28	$20.34	$6.86
88371	A	Protein, western blot tissue					
88372	A	Protein analysis w/probe					
88399	X	Surgical pathology procedure	881	0.20	$10.77	$6.78	$2.15
89050	A	Body fluid cell count					
89051	A	Body fluid cell count					
89060	A	Exam,synovial fluid crystals					
89100	X	Sample intestinal contents	928	3.11	$164.55	$83.85	$32.91
89105	X	Sample intestinal contents	928	3.11	$164.55	$83.85	$32.91
89125	A	Specimen fat stain					
89130	X	Sample stomach contents	928	3.11	$164.55	$83.85	$32.91
89132	X	Sample stomach contents	928	3.11	$164.55	$83.85	$32.91
89135	X	Sample stomach contents	928	3.11	$164.55	$83.85	$32.91
89136	X	Sample stomach contents	928	3.11	$164.55	$83.85	$32.91
89140	X	Sample stomach contents	928	3.11	$164.55	$83.85	$32.91
89141	X	Sample stomach contents	928	3.11	$164.55	$83.85	$32.91
89160	A	Exam feces for meat fibers					
89190	A	Nasal smear for eosinophils					
89250	A	Fertilization of oocyte					
89251	A	Culture oocyte w/embryos					
89252	A	Assist oocyte fertilization					
89253	A	Embryo hatching					
89254	A	Oocyte identification					
89255	A	Prepare embryo for transfer					
89256	A	Prepare cryopreserved embryo					
89257	A	Sperm identification					
89258	A	Cryopreservation, embryo					
89259	A	Cryopreservation, sperm					
89260	A	Sperm isolation, simple					
89261	A	Sperm isolation, complex					
89300	A	Semen analysis					
89310	A	Semen analysis					
89320	A	Semen analysis					
89325	A	Sperm antibody test					
89329	A	Sperm evaluation test					
89330	A	Evaluation, cervical mucus					
89350	X	Sputum specimen collection	881	0.20	$10.77	$6.78	$2.15
89355	A	Exam feces for starch					
89360	X	Collect sweat for test	881	0.20	$10.77	$6.78	$2.15
89365	A	Water load test					
89399	X	Pathology lab procedure	881	0.20	$10.77	$6.78	$2.15
90700	X	DTaP immunization	901	0.07	$3.92	$2.49	0.78
90701	X	DTP immunization	901	0.07	$3.92	$2.49	0.78
90702	X	DT immunization	901	0.07	$3.92	$2.49	0.78
90703	X	Tetanus immunization	901	0.07	$3.92	$2.49	0.78
90704	X	Mumps immunization	901	0.07	$3.92	$2.49	0.78
90705	X	Measles immunization	901	0.07	$3.92	$2.49	0.78
90706	X	Rubella immunization	901	0.07	$3.92	$2.49	0.78
90707	X	MMR virus immunization	902	1.78	$94.03	$41.58	$18.81
90708	X	Measles-rubella immunization	901	0.07	$3.92	$2.49	0.78
90709	X	Rubella & mumps immunization	901	0.07	$3.92	$2.49	0.78
90710	X	Combined vaccine	901	0.07	$3.92	$2.49	0.78
90711	X	Combined vaccine	901	0.07	$3.92	$2.49	0.78
90712	X	Oral poliovirus immunization	902	1.78	$94.03	$41.58	$18.81
90713	X	Poliomyelitis immunization	902	1.78	$94.03	$41.58	$18.81
90714	X	Typhoid immunization	901	0.07	$3.92	$2.49	0.78
90716	X	Chicken pox vaccine	902	1.78	$94.03	$41.58	$18.81
90717	X	Yellow fever immunization	902	1.78	$94.03	$41.58	$18.81
90718	X	Td immunization	901	0.07	$3.92	$2.49	0.78
90719	X	Diphtheria immunization	901	0.07	$3.92	$2.49	0.78
90720	X	DTP/HIB vaccine	902	1.78	$94.03	$41.58	$18.81
90721	X	Dtap/hib vaccine	903	1.17	$61.71	$25.76	$12.34
90724	X	Influenza immunization	901	0.07	$3.92	$2.49	0.78
90725	X	Cholera immunization	901	0.07	$3.92	$2.49	0.78
90726	X	Rabies immunization	903	1.17	$61.71	$25.76	$12.34

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
90727	X	Plague immunization	903	1.17	$61.71	$25.76	$12.34
90728	X	BCG immunization	903	1.17	$61.71	$25.76	$12.34
90730	X	Hepatitis A vaccine	901	0.07	$3.92	$2.49	0.78
90732	X	Pneumococcal immunization	901	0.07	$3.92	$2.49	0.78
90733	X	Meningococcal immunization	902	1.78	$94.03	$41.58	$18.81
90735	X	Encephalitis virus vaccine	903	1.17	$61.71	$25.76	$12.34
90737	X	Influenza B immunization	902	1.78	$94.03	$41.58	$18.81
90741	X	Passive immunization, ISG	902	1.78	$94.03	$41.58	$18.81
90742	X	Special passive immunization	903	1.17	$61.71	$25.76	$12.34
90744	X	Hepatitis B vaccine, under 11	902	1.78	$94.03	$41.58	$18.81
90745	X	Hepatitis B vaccine, 11–19	902	1.78	$94.03	$41.58	$18.81
90746	X	Hepatitis B vaccine, over 20	902	1.78	$94.03	$41.58	$18.81
90747	X	Hepatitis B vaccine, ill pat	902	1.78	$94.03	$41.58	$18.81
90748	X	Hepatitis b/hib vaccine	901	0.07	$3.92	$2.49	0.78
90749	X	Immunization procedure	901	0.07	$3.92	$2.49	0.78
90780	X	IV infusion therapy, 1 hour	906	1.46	$77.38	$42.49	$15.48
90781	X	IV infusion, additional hour	906	1.46	$77.38	$42.49	$15.48
90782	X	Injection (SC)/(IM)	907	0.85	$45.05	$11.98	$9.01
90783	X	Injection (IA)	907	0.85	$45.05	$11.98	$9.01
90784	X	Injection (IV)	907	0.85	$45.05	$11.98	$9.01
90788	X	Injection of antibiotic	907	0.85	$45.05	$11.98	$9.01
90799	X	Therapeutic/diag injection	907	0.85	$45.05	$11.98	$9.01
90801	S	Psy dx interview	092	1.57	$83.25	$21.92	$16.65
90802	S	Intac psy dx interview	092	1.57	$83.25	$21.92	$16.65
90804	S	Psytx, office (20–30)	091	1.19	$62.69	$15.37	$12.54
90805	S	Psytx, office (20–30) w/e&m	091	1.19	$62.69	$15.37	$12.54
90806	S	Psytx, office (45–50)	092	1.57	$83.25	$21.92	$16.65
90807	S	Psytx, office (45–50) w/e&m	092	1.57	$83.25	$21.92	$16.65
90808	S	Psytx, office (75–80)	092	1.57	$83.25	$21.92	$16.65
90809	S	Psytx, office (75–80) w/e&m	092	1.57	$83.25	$21.92	$16.65
90810	S	Intac psytx, office (20–30)	091	1.19	$62.69	$15.37	$12.54
90811	S	Intac psytx, off 20–30 w/e&m	091	1.19	$62.69	$15.37	$12.54
90812	S	Intac psytx, office (45–50)	092	1.57	$83.25	$21.92	$16.65
90813	S	Intac psytx, off 45–50 w/e&m	092	1.57	$83.25	$21.92	$16.65
90814	S	Intac psytx, office (75–80)	092	1.57	$83.25	$21.92	$16.65
90815	S	Intac psytx, off 75–80 w/e&m	092	1.57	$83.25	$21.92	$16.65
90816	S	Psytx, hosp (20–30)	091	1.19	$62.69	$15.37	$12.54
90817	S	Psytx, hosp (20–30) w/e&m	091	1.19	$62.69	$15.37	$12.54
90818	S	Psytx, hosp (45–50)	092	1.57	$83.25	$21.92	$16.65
90819	S	Psytx, hosp (45–50) w/e&m	092	1.57	$83.25	$21.92	$16.65
90821	S	Psytx, hosp (75–80)	092	1.57	$83.25	$21.92	$16.65
90822	S	Psytx, hosp (75–80) w/e&m	092	1.57	$83.25	$21.92	$16.65
90823	S	Intac psytx, hosp (20–30)	091	1.19	$62.69	$15.37	$12.54
90824	S	Intac psytx, hsp 20–30 w/e&m	091	1.19	$62.69	$15.37	$12.54
90826	S	Intac psytx, hosp (45–50)	092	1.57	$83.25	$21.92	$16.65
90827	S	Intac psytx, hsp 45–50 w/e&m	092	1.57	$83.25	$21.92	$16.65
90828	S	Intac psytx, hosp (75–80)	092	1.57	$83.25	$21.92	$16.65
90829	S	Intac psytx, hsp 75–80 w/e&m	092	1.57	$83.25	$21.92	$16.65
90845	S	Psychoanalysis	092	1.57	$83.25	$21.92	$16.65
90846	S	Family psytx w/o patient	093	1.54	$81.29	$20.11	$16.26
90847	S	Family psytx w/patient	093	1.54	$81.29	$20.11	$16.26
90849	S	Multiple family group psytx	094	1.24	$65.62	$20.11	$13.12
90853	S	Group psychotherapy	094	1.24	$65.62	$20.11	$13.12
90857	S	Intac group psytx	094	1.24	$65.62	$20.11	$13.12
90862	X	Medication management	090	0.85	$45.05	$12.43	$9.01
90865	S	Narcosynthesis	092	1.57	$83.25	$21.92	$16.65
90870	S	Electroconvulsive therapy	919	3.17	$167.49	$80.00	$33.50
90871	S	Electroconvulsive therapy	919	3.17	$167.49	$80.00	$33.50
90875	E	Psychophysiological therapy	.....	.....	.....	.....	.....
90876	E	Psychophysiological therapy	.....	.....	.....	.....	.....
90880	S	Hypnotherapy	092	1.57	$83.25	$21.92	$16.65
90882	E	Environmental manipulation	.....	.....	.....	.....	.....
90885	N	Psy evaluation of records	.....	.....	.....	.....	.....
90887	N	Consultation with family	.....	.....	.....	.....	.....
90889	N	Preparation of report	.....	.....	.....	.....	.....
90899	S	Psychiatric service/therapy	091	1.19	$62.69	$15.37	$12.54
90901	S	Biofeedback, any method	920	1.17	$61.71	$29.61	$12.34
90911	S	Biofeedback peri/uro/rectal	920	1.17	$61.71	$29.61	$12.34
90918	A	ESRD related services, month	.....	.....	.....	.....	.....
90919	A	ESRD related services, month	.....	.....	.....	.....	.....
90920	A	ESRD related services, month	.....	.....	.....	.....	.....
90921	A	ESRD related services, month	.....	.....	.....	.....	.....
90922	A	ESRD related services, day	.....	.....	.....	.....	.....
90923	A	Esrd related services, day	.....	.....	.....	.....	.....
90924	A	Esrd related services, day	.....	.....	.....	.....	.....

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
90925	A	Esrd related services, day	.....	.....	.....	.....	.....
90935	S	Hemodialysis, one evaluation	926	4.28	$226.25	$69.83	$45.25
90937	S	Hemodialysis, repeated eval	926	4.28	$226.25	$69.83	$45.25
90945	S	Dialysis, one evaluation	926	4.28	$226.25	$69.83	$45.25
90947	S	Dialysis, repeated eval	926	4.28	$226.25	$69.83	$45.25
90989	E	Dialysis training/complete	.....	.....	.....	.....	.....
90993	N	Dialysis training/incomplete	.....	.....	.....	.....	.....
90997	S	Hemoperfusion	926	4.28	$226.25	$69.83	$45.25
90999	S	Dialysis procedure	926	4.28	$226.25	$69.83	$45.25
91000	X	Esophageal intubation	928	3.11	$164.55	$83.85	$32.91
91010	X	Esophagus motility study	928	3.11	$164.55	$83.85	$32.91
91011	X	Esophagus motility study	928	3.11	$164.55	$83.85	$32.91
91012	X	Esophagus motility study	928	3.11	$164.55	$83.85	$32.91
91020	X	Gastric motility	928	3.11	$164.55	$83.85	$32.91
91030	X	Acid perfusion of esophagus	928	3.11	$164.55	$83.85	$32.91
91032	X	Esophagus, acid reflux test	928	3.11	$164.55	$83.85	$32.91
91033	X	Prolonged acid reflux test	928	3.11	$164.55	$83.85	$32.91
91052	X	Gastric analysis test	928	3.11	$164.55	$83.85	$32.91
91055	X	Gastric intubation for smear	928	3.11	$164.55	$83.85	$32.91
91060	X	Gastric saline load test	928	3.11	$164.55	$83.85	$32.91
91065	X	Breath hydrogen test	928	3.11	$164.55	$83.85	$32.91
91100	X	Pass intestine bleeding tube	928	3.11	$164.55	$83.85	$32.91
91105	X	Gastric intubation treatment	928	3.11	$164.55	$83.85	$32.91
91122	N	Anal pressure record	.....	.....	.....	.....	.....
91299	X	Gastroenterology procedure	928	3.11	$164.55	$83.85	$32.91
92002	V	Eye exam, new patient	913	.....	.....	.....	.....
92004	V	Eye exam, new patient	915	.....	.....	.....	.....
92012	V	Eye exam established pt	913	.....	.....	.....	.....
92014	V	Eye exam & treatment	915	.....	.....	.....	.....
92015	E	Refraction	.....	.....	.....	.....	.....
92018	T	New eye exam & treatment	676	6.30	$333.01	$140.35	$66.6
92019	T	Eye exam & treatment	676	6.30	$333.01	$140.35	$66.6
92020	N	Special eye evaluation	.....	.....	.....	.....	.....
92060	X	Special eye evaluation	930	1.02	$53.87	$22.83	$10.77
92065	X	Orthoptic/pleoptic training	930	1.02	$53.87	$22.83	$10.77
92070	N	Fitting of contact lens	.....	.....	.....	.....	.....
92081	X	Visual field examination(s)	930	1.02	$53.87	$22.83	$10.77
92082	X	Visual field examination(s)	930	1.02	$53.87	$22.83	$10.77
92083	X	Visual field examination(s)	930	1.02	$53.87	$22.83	$10.77
92100	N	Serial tonometry exam(s)	.....	.....	.....	.....	.....
92120	X	Tonography & eye evaluation	931	0.74	$39.18	$21.47	$7.84
92130	X	Water provocation tonography	931	0.74	$39.18	$21.47	$7.84
92140	X	Glaucoma provocative tests	930	1.02	$53.87	$22.83	$10.77
92225	N	Special eye exam, initial	.....	.....	.....	.....	.....
92226	N	Special eye exam, subsequent	.....	.....	.....	.....	.....
92230	X	Eye exam with photos	931	0.74	$39.18	$21.47	$7.84
92235	X	Eye exam with photos	932	2.52	$133.21	$65.09	$26.64
92240	X	Icg angiography	931	0.74	$39.18	$21.47	$7.84
92250	X	Eye exam with photos	931	0.74	$39.18	$21.47	$7.84
92260	N	Ophthalmoscopy/dynamometry	.....	.....	.....	.....	.....
92265	X	Eye muscle evaluation	932	2.52	$133.21	$65.09	$26.64
92270	X	Electro-oculography	932	2.52	$133.21	$65.09	$26.64
92275	X	Electroretinography	981	1.46	$77.38	$41.81	$15.48
92283	X	Color vision examination	930	1.02	$53.87	$22.83	$10.77
92284	X	Dark adaptation eye exam	930	1.02	$53.87	$22.83	$10.77
92285	X	Eye photography	930	1.02	$53.87	$22.83	$10.77
92286	X	Internal eye photography	932	2.52	$133.21	$65.09	$26.64
92287	X	Internal eye photography	932	2.52	$133.21	$65.09	$26.64
92310	E	Contact lens fitting	.....	.....	.....	.....	.....
92311	X	Contact lens fitting	936	0.52	$27.42	$9.49	$5.48
92312	X	Contact lens fitting	936	0.52	$27.42	$9.49	$5.48
92313	X	Contact lens fitting	936	0.52	$27.42	$9.49	$5.48
92314	E	Prescription of contact lens	.....	.....	.....	.....	.....
92315	X	Prescription of contact lens	936	0.52	$27.42	$9.49	$5.48
92316	X	Prescription of contact lens	936	0.52	$27.42	$9.49	$5.48
92317	X	Prescription of contact lens	936	0.52	$27.42	$9.49	$5.48
92325	X	Modification of contact lens	936	0.52	$27.42	$9.49	$5.48
92326	X	Replacement of contact lens	936	0.52	$27.42	$9.49	$5.48
92330	X	Fitting of artificial eye	936	0.52	$27.42	$9.49	$5.48
92335	N	Fitting of artificial eye	.....	.....	.....	.....	.....
92340	E	Fitting of spectacles	.....	.....	.....	.....	.....
92341	E	Fitting of spectacles	.....	.....	.....	.....	.....
92342	E	Fitting of spectacles	.....	.....	.....	.....	.....
92352	X	Special spectacles fitting	936	0.52	$27.42	$9.49	$5.48
92353	X	Special spectacles fitting	936	0.52	$27.42	$9.49	$5.48

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
92354	X	Special spectacles fitting	936	0.52	$27.42	$9.49	$5.48
92355	X	Special spectacles fitting	936	0.52	$27.42	$9.49	$5.48
92358	X	Eye prosthesis service	936	0.52	$27.42	$9.49	$5.48
92370	E	Repair & adjust spectacles					
92371	X	Repair & adjust spectacles	936	0.52	$27.42	$9.49	$5.48
92390	E	Supply of spectacles					
92391	E	Supply of contact lenses					
92392	E	Supply of low vision aids					
92393	E	Supply of artificial eye					
92395	E	Supply of spectacles					
92396	E	Supply of contact lenses					
92499	X	Eye service or procedure	931	0.74	$39.18	$21.47	$7.84
92502	T	Ear and throat examination	311	1.43	$75.42	$20.57	$15.08
92504	N	Ear microscopy examination					
92506	A	Speech & hearing evaluation					
92507	A	Speech/hearing therapy					
92508	A	Speech/hearing therapy					
92510	A	Rehab for ear implant					
92511	T	Nasopharyngos- copy	331	0.69	$36.24	$14.01	$7.25
92512	X	Nasal function studies	940	3.04	$160.63	$51.98	$32.13
92516	X	Facial nerve function test	940	3.04	$160.63	$51.98	$32.13
92520	X	Laryngeal function studies	940	3.04	$160.63	$51.98	$32.13
92525	A	Oral function evaluation					
92526	A	Oral function therapy					
92531	N	Spontaneous nystagmus study					
92532	N	Positional nystagmus study					
92533	N	Caloric vestibular test					
92534	N	Optokinetic nystagmus					
92541	X	Spontaneous nystagmus test	940	3.04	$160.63	$51.98	$32.13
92542	X	Positional nystagmus test	940	3.04	$160.63	$51.98	$32.13
92543	X	Caloric vestibular test	940	3.04	$160.63	$51.98	$32.13
92544	X	Optokinetic nystagmus test	940	3.04	$160.63	$51.98	$32.13
92545	X	Oscillating tracking test	940	3.04	$160.63	$51.98	$32.13
92546	X	Sinusoidal rotational test	940	3.04	$160.63	$51.98	$32.13
92547	X	Supplemental electrical test	940	3.04	$160.63	$51.98	$32.13
92548	X	Posturography	940	3.04	$160.63	$51.98	$32.13
92551	E	Pure tone hearing test, air					
92552	X	Pure tone audiometry, air	941	0.74	$39.18	$13.56	$7.84
92553	X	Audiometry, air & bone	941	0.74	$39.18	$13.56	$7.84
92555	X	Speech threshold audiometry	941	0.74	$39.18	$13.56	$7.84
92556	X	Speech audiometry, complete	941	0.74	$39.18	$13.56	$7.84
92557	X	Comprehensive hearing test	942	1.48	$78.36	$22.15	$15.67
92559	E	Group audiometric testing					
92560	E	Bekesy audiometry, screen					
92561	X	Bekesy audiometry, diagnosis	942	1.48	$78.36	$22.15	$15.67
92562	X	Loudness balance test	942	1.48	$78.36	$22.15	$15.67
92563	X	Tone decay hearing test	942	1.48	$78.36	$22.15	$15.67
92564	X	Sisi hearing test	942	1.48	$78.36	$22.15	$15.67
92565	X	Stenger test, pure tone	942	1.48	$78.36	$22.15	$15.67
92567	X	Tympanometry	941	0.74	$39.18	$13.56	$7.84
92568	X	Acoustic reflex testing	942	1.48	$78.36	$22.15	$15.67
92569	X	Acoustic reflex decay test	942	1.48	$78.36	$22.15	$15.67
92571	X	Filtered speech hearing test	942	1.48	$78.36	$22.15	$15.67
92572	X	Staggered spondaic word test	942	1.48	$78.36	$22.15	$15.67
92573	X	Lombard test	942	1.48	$78.36	$22.15	$15.67
92575	X	Sensorineural acuity test	942	1.48	$78.36	$22.15	$15.67
92576	X	Synthetic sentence test	942	1.48	$78.36	$22.15	$15.67
92577	X	Stenger test, speech	942	1.48	$78.36	$22.15	$15.67
92579	X	Visual audiometry (vra)	942	1.48	$78.36	$22.15	$15.67
92582	X	Conditioning play audiometry	942	1.48	$78.36	$22.15	$15.67
92583	X	Select picture audiometry	942	1.48	$78.36	$22.15	$15.67
92584	X	Electrocochleography	940	3.04	$160.63	$51.98	$32.13
92585	X	Auditory evoked potential	982	1.39	$73.46	$38.87	$14.69
92587	X	Evoked auditory test	940	3.04	$160.63	$51.98	$32.13
92588	X	Evoked auditory test	940	3.04	$160.63	$51.98	$32.13
92589	X	Auditory function test(s)	942	1.48	$78.36	$22.15	$15.67
92590	E	Hearing aid exam, one ear					
92591	E	Hearing aid exam, both ears					
92592	E	Hearing aid check, one ear					
92593	E	Hearing aid check, both ears					
92594	E	Electro hearing aid test, one					
92595	E	Electro hearing aid test, both					
92596	X	Ear protector evaluation	942	1.48	$78.36	$22.15	$15.67
92597	A	Oral speech device eval					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
92598	A	Modify oral speech device	.....	.....	.....	.....	.....
92599	X	ENT procedure/service	941	0.74	$39.18	$13.56	$7.84
92950	S	Heart/lung resuscitation(CPR	947	4.07	$215.48	$109.61	$43.10
92953	S	Temporary external pacing	947	4.07	$215.48	$109.61	$43.10
92960	S	Heart electroconversion	947	4.07	$215.48	$109.61	$43.10
92970	C	Cardioassist, internal	.....	.....	.....	.....	.....
92971	C	Cardioassist, external	.....	.....	.....	.....	.....
92975	C	Dissolve clot, heart vessel	.....	.....	.....	.....	.....
92977	C	Dissolve clot, heart vessel	.....	.....	.....	.....	.....
92978	C	Intravas us, heart (add-on)	.....	.....	.....	.....	.....
92979	C	Intravas us, heart (add-on)	.....	.....	.....	.....	.....
92980	C	Insert intracoronary stent	.....	.....	.....	.....	.....
92981	C	Insert intracoronary stent	.....	.....	.....	.....	.....
92982	C	Coronary artery dilation	.....	.....	.....	.....	.....
92984	C	Coronary artery dilation	.....	.....	.....	.....	.....
92986	C	Revision of aortic valve	.....	.....	.....	.....	.....
92987	C	Revision of mitral valve	.....	.....	.....	.....	.....
92990	C	Revision of pulmonary valve	.....	.....	.....	.....	.....
92992	C	Revision of heart chamber	.....	.....	.....	.....	.....
92993	C	Revision of heart chamber	.....	.....	.....	.....	.....
92995	C	Coronary atherectomy	.....	.....	.....	.....	.....
92996	C	Coronary atherectomy	.....	.....	.....	.....	.....
92997	C	Pul art balloon repair, perc	.....	.....	.....	.....	.....
92998	C	Pul art balloon repair, perc	.....	.....	.....	.....	.....
93000	N	Electrocardiogram, complete	.....	.....	.....	.....	.....
93005	X	Electrocardiogram, tracing	950	0.35	$18.61	$15.82	$3.72
93010	N	Electrocardiogram report	.....	.....	.....	.....	.....
93012	X	Transmission of ecg	956	1.11	$58.77	$55.82	$11.75
93014	N	Report on transmitted ecg	.....	.....	.....	.....	.....
93015	N	Cardiovascular stress test	.....	.....	.....	.....	.....
93016	N	Cardiovascular stress test	.....	.....	.....	.....	.....
93017	X	Cardiovascular stress test	949	1.46	$77.38	$62.83	$15.48
93018	N	Cardiovascular stress test	.....	.....	.....	.....	.....
93024	X	Cardiac drug stress test	949	1.46	$77.38	$62.83	$15.48
93040	N	Rhythm ECG with report	.....	.....	.....	.....	.....
93041	X	Rhythm ECG, tracing	950	0.35	$18.61	$15.82	$3.72
93042	N	Rhythm ECG, report	.....	.....	.....	.....	.....
93224	X	ECG monitor/report, 24 hrs	956	1.11	$58.77	$55.82	$11.75
93225	X	ECG monitor/record, 24 hrs	956	1.11	$58.77	$55.82	$11.75
93226	X	ECG monitor/report, 24 hrs	956	1.11	$58.77	$55.82	$11.75
93227	N	ECG monitor/review, 24 hrs	.....	.....	.....	.....	.....
93230	X	ECG monitor/report, 24 hrs	956	1.11	$58.77	$55.82	$11.75
93231	X	Ecg monitor/record, 24 hrs	956	1.11	$58.77	$55.82	$11.75
93232	X	ECG monitor/report, 24 hrs	956	1.11	$58.77	$55.82	$11.75
93233	N	ECG monitor/review, 24 hrs	.....	.....	.....	.....	.....
93235	X	ECG monitor/report, 24 hrs	956	1.11	$58.77	$55.82	$11.75
93236	X	ECG monitor/report, 24 hrs	956	1.11	$58.77	$55.82	$11.75
93237	N	ECG monitor/review, 24 hrs	.....	.....	.....	.....	.....
93268	X	ECG record/review	956	1.11	$58.77	$55.82	$11.75
93270	X	ECG recording	956	1.11	$58.77	$55.82	$11.75
93271	X	Ecg/monitoring and anaylysis	956	1.11	$58.77	$55.82	$11.75
93272	N	Ecg/review,interpret only	.....	.....	.....	.....	.....
93278	X	ECG/signal-averaged	956	1.11	$58.77	$55.82	$11.75
93303	X	Echo transthoracic	957	2.83	$149.86	$117.07	$29.97
93304	X	Echo transthoracic	957	2.83	$149.86	$117.07	$29.97
93307	X	Echo exam of heart	957	2.83	$149.86	$117.07	$29.97
93308	X	Echo exam of heart	957	2.83	$149.86	$117.07	$29.97
93312	X	Echo transesophageal	957	2.83	$149.86	$117.07	$29.97
93313	X	Echo transesophageal	957	2.83	$149.86	$117.07	$29.97
93314	N	Echo transesophageal	.....	.....	.....	.....	.....
93315	X	Echo transesophageal	957	2.83	$149.86	$117.07	$29.97
93316	X	Echo transesophageal	957	2.83	$149.86	$117.07	$29.97
93317	N	Echo transesophageal	.....	.....	.....	.....	.....
93320	X	Doppler echo exam, heart	957	2.83	$149.86	$117.07	$29.97
93321	X	Doppler echo exam, heart	957	2.83	$149.86	$117.07	$29.97
93325	X	Doppler color flow	957	2.83	$149.86	$117.07	$29.97
93350	X	Echo transthoracic	957	2.83	$149.86	$117.07	$29.97
93501	T	Right heart catheterization	958	26.11	$1,381.03	$659.47	$276.21
93503	T	Insert/place heart catheter	958	26.11	$1,381.03	$659.47	$276.21
93505	T	Biopsy of heart lining	958	26.11	$1,381.03	$659.47	$276.21
93508	T	Cath placement, angiography	343	9.52	$503.44	$224.87	$100.69
93510	T	Left heart catheterization	958	26.11	$1,381.03	$659.47	$276.21
93511	T	Left heart catheterization	958	26.11	$1,381.03	$659.47	$276.21
93514	T	Left heart catheterization	958	26.11	$1,381.03	$659.47	$276.21
93524	T	Left heart catheterization	958	26.11	$1,381.03	$659.47	$276.21

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
93526	T	Rt & Lt heart catheters	958	26.11	$1,381.03	$659.47	$276.21
93527	T	Rt & Lt heart catheters	958	26.11	$1,381.03	$659.47	$276.21
93528	T	Rt & Lt heart catheters	958	26.11	$1,381.03	$659.47	$276.21
93529	T	Rt, Lt heart catheterization	958	26.11	$1,381.03	$659.47	$276.21
93530	T	Rt heart cath, congenital	958	26.11	$1,381.03	$659.47	$276.21
93531	T	R & l heart cath, congenital	958	26.11	$1,381.03	$659.47	$276.21
93532	T	R & l heart cath, congenital	958	26.11	$1,381.03	$659.47	$276.21
93533	T	R & l heart cath, congenital	958	26.11	$1,381.03	$659.47	$276.21
93536	T	Insert circulation assi	958	26.11	$1,381.03	$659.47	$276.21
93539	N	Injection, cardiac cath					
93540	N	Injection, cardiac cath					
93541	N	Injection for lung angiogram					
93542	N	Injection for heart x-rays					
93543	N	Injection for heart x-rays					
93544	N	Injection for aortography					
93545	N	Injection for coronary xrays					
93555	N	Imaging, cardiac cath					
93556	N	Imaging, cardiac cath					
93561	N	Cardiac output measurement					
93562	N	Cardiac output measurement					
93600	S	Bundle of His recording	960	4.24	$224.29	$144.41	$44.86
93602	S	Intra-atrial recording	960	4.24	$224.29	$144.41	$44.86
93603	S	Right ventricular recording	960	4.24	$224.29	$144.41	$44.86
93607	S	Right ventricular recording	960	4.24	$224.29	$144.41	$44.86
93609	S	Mapping of tachycardia	960	4.24	$224.29	$144.41	$44.86
93610	S	Intra-atrial pacing	960	4.24	$224.29	$144.41	$44.86
93612	S	Intraventricular pacing	960	4.24	$224.29	$144.41	$44.86
93615	S	Esophageal recording	960	4.24	$224.29	$144.41	$44.86
93616	S	Esophageal recording	960	4.24	$224.29	$144.41	$44.86
93618	S	Heart rhythm pacing	960	4.24	$224.29	$144.41	$44.86
93619	S	Electrophysiology evaluation	960	4.24	$224.29	$144.41	$44.86
93620	S	Electrophysiology evaluation	960	4.24	$224.29	$144.41	$44.86
93621	S	Electrophysiology evaluation	960	4.24	$224.29	$144.41	$44.86
93622	S	Electrophysiology evaluation	960	4.24	$224.29	$144.41	$44.86
93623	S	Stimulation, pacing heart	960	4.24	$224.29	$144.41	$44.86
93624	S	Electrophysiologic study	960	4.24	$224.29	$144.41	$44.86
93631	S	Heart pacing, mapping	960	4.24	$224.29	$144.41	$44.86
93640	S	Evaluation heart device	960	4.24	$224.29	$144.41	$44.86
93641	S	Electrophysiology evaluation	960	4.24	$224.29	$144.41	$44.86
93642	S	Electrophysiology evaluation	960	4.24	$224.29	$144.41	$44.86
93650	S	Ablate heart dysrhythm focus	960	4.24	$224.29	$144.41	$44.86
93651	S	Ablate heart dysrhythm focus	960	4.24	$224.29	$144.41	$44.86
93652	S	Ablate heart dysrhythm focus	960	4.24	$224.29	$144.41	$44.86
93660	S	Tilt table evaluation	960	4.24	$224.29	$144.41	$44.86
93720	X	Total body plethysmography	967	1.70	$90.11	$57.40	$18.02
93721	X	Plethysmography tracing	967	1.70	$90.11	$57.40	$18.02
93722	N	Plethysmography report					
93724	S	Analyze pacemaker system	960	4.24	$224.29	$144.41	$44.86
93731	X	Analyze pacemaker system	966	0.39	$20.57	$12.43	$4.11
93732	X	Analyze pacemaker system	966	0.39	$20.57	$12.43	$4.11
93733	X	Telephone analysis, pacemaker	966	0.39	$20.57	$12.43	$4.11
93734	X	Analyze pacemaker system	966	0.39	$20.57	$12.43	$4.11
93735	X	Analyze pacemaker system	966	0.39	$20.57	$12.43	$4.11
93736	X	Telephone analysis, pacemaker	966	0.39	$20.57	$12.43	$4.11
93737	X	Analyze cardio/defibrillator	966	0.39	$20.57	$12.43	$4.11
93738	X	Analyze cardio/defibrillator	966	0.39	$20.57	$12.43	$4.11
93740	X	Temperature gradient studies	967	1.70	$90.11	$57.40	$18.02
93760	E	Cephalic thermogram					
93762	E	Peripheral thermogram					
93770	N	Measure venous pressure					
93784	E	Ambulatory BP monitoring					
93786	E	Ambulatory BP recording					
93788	E	Ambulatory BP analysis					
93790	E	Review/report BP recording					
93797	X	Cardiac rehab	948	0.81	$43.10	$16.95	$8.62
93798	X	Cardiac rehab/monitor	948	0.81	$43.10	$16.95	$8.62
93799	X	Cardiovascular procedure	967	1.70	$90.11	$57.40	$18.02
93875	X	Extracranial study	968	2.37	$125.37	$79.55	$25.07
93880	X	Extracranial study	968	2.37	$125.37	$79.55	$25.07
93882	X	Extracranial study	968	2.37	$125.37	$79.55	$25.07
93886	X	Intracranial study	968	2.37	$125.37	$79.55	$25.07
93888	X	Intracranial study	968	2.37	$125.37	$79.55	$25.07
93922	X	Extremity study	967	1.70	$90.11	$57.40	$18.02
93923	X	Extremity study	967	1.70	$90.11	$57.40	$18.02
93924	X	Extremity study	967	1.70	$90.11	$57.40	$18.02

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
93925	X	Lower extremity study	968	2.37	$125.37	$79.55	$25.07
93926	X	Lower extremity study	968	2.37	$125.37	$79.55	$25.07
93930	X	Upper extremity study	968	2.37	$125.37	$79.55	$25.07
93931	X	Upper extremity study	968	2.37	$125.37	$79.55	$25.07
93965	X	Extremity study	967	1.70	$90.11	$57.40	$18.02
93970	X	Extremity study	968	2.37	$125.37	$79.55	$25.07
93971	X	Extremity study	968	2.37	$125.37	$79.55	$25.07
93975	X	Vascular study	968	2.37	$125.37	$79.55	$25.07
93976	X	Vascular study	968	2.37	$125.37	$79.55	$25.07
93978	X	Vascular study	968	2.37	$125.37	$79.55	$25.07
93979	X	Vascular study	968	2.37	$125.37	$79.55	$25.07
93980	X	Penile vascular study	968	2.37	$125.37	$79.55	$25.07
93981	X	Penile vascular study	968	2.37	$125.37	$79.55	$25.07
93990	X	Doppler flow testing	968	2.37	$125.37	$79.55	$25.07
94010	X	Breathing capacity test	971	0.78	$41.14	$21.47	$8.23
94060	X	Evaluation of wheezing	971	0.78	$41.14	$21.47	$8.23
94070	S	Evaluation of wheezing	973	1.89	$99.90	$55.82	$19.98
94150	N	Vital capacity test	.....	.....	.....	.....	.....
94200	X	Lung function test (MBC/MVV)	971	0.78	$41.14	$21.47	$8.23
94240	X	Residual lung capacity	972	1.02	$53.87	$29.38	$10.77
94250	X	Expired gas collection	971	0.78	$41.14	$21.47	$8.23
94260	X	Thoracic gas volume	971	0.78	$41.14	$21.47	$8.23
94350	X	Lung nitrogen washout curve	972	1.02	$53.87	$29.38	$10.77
94360	X	Measure airflow resistance	971	0.78	$41.14	$21.47	$8.23
94370	X	Breath airway closing volume	972	1.02	$53.87	$29.38	$10.77
94375	X	Respiratory flow volume loop	971	0.78	$41.14	$21.47	$8.23
94400	X	CO2 breathing response curve	971	0.78	$41.14	$21.47	$8.23
94450	X	Hypoxia response curve	971	0.78	$41.14	$21.47	$8.23
94620	S	Pulmonary stress testing	973	1.89	$99.90	$55.82	$19.98
94640	S	Airway inhalation treatment	976	0.44	$23.30	$14.92	$4.66
94642	S	Aerosol inhalation treatment	976	0.44	$23.30	$14.92	$4.66
94650	S	Pressure breathing (IPPB)	976	0.44	$23.30	$14.92	$4.66
94651	S	Pressure breathing (IPPB)	976	0.44	$23.30	$14.92	$4.66
94652	C	Pressure breathing (IPPB)	.....	.....	.....	.....	.....
94656	C	Initial ventilator mgmt	.....	.....	.....	.....	.....
94657	S	Cont. ventilator	976	0.44	$23.30	$14.92	$4.66
94660	S	Pos airway pressure, CPAP	976	0.44	$23.30	$14.92	$4.66
94662	S	Neg pressure ventilation,cnp	976	0.44	$23.30	$14.92	$4.66
94664	S	Aerosol or vapor inhalations	976	0.44	$23.30	$14.92	$4.66
94665	S	Aerosol or vapor inhalations	976	0.44	$23.30	$14.92	$4.66
94667	S	Chest wall manipulation	976	0.44	$23.30	$14.92	$4.66
94668	S	Chest wall manipulation	976	0.44	$23.30	$14.92	$4.66
94680	X	Exhaled air analysis: O2	972	1.02	$53.87	$29.38	$10.77
94681	X	Exhaled air analysis: O2,CO2	972	1.02	$53.87	$29.38	$10.77
94690	X	Exhaled air analysis	972	1.02	$53.87	$29.38	$10.77
94720	X	Monoxide diffusing capacity	972	1.02	$53.87	$29.38	$10.77
94725	X	Membrane diffusion capacity	972	1.02	$53.87	$29.38	$10.77
94750	S	Pulmonary compliance study	973	1.89	$99.90	$55.82	$19.98
94760	N	Measure blood oxygen level	.....	.....	.....	.....	.....
94761	N	Measure blood oxygen level	.....	.....	.....	.....	.....
94762	X	Measure blood oxygen level	971	0.78	$41.14	$21.47	$8.23
94770	X	Exhaled carbon dioxide test	971	0.78	$41.14	$21.47	$8.23
94772	S	Breath recording, infant	973	1.89	$99.90	$55.82	$19.98
94799	X	Pulmonary service/procedure	971	0.78	$41.14	$21.47	$8.23
95004	X	Allergy skin tests	977	0.63	$33.30	$12.66	$6.66
95010	X	Sensitivity skin tests	977	0.63	$33.30	$12.66	$6.66
95015	X	Sensitivity skin tests	977	0.63	$33.30	$12.66	$6.66
95024	X	Allergy skin tests	977	0.63	$33.30	$12.66	$6.66
95027	X	Skin end point titration	977	0.63	$33.30	$12.66	$6.66
95028	X	Allergy skin tests	977	0.63	$33.30	$12.66	$6.66
95044	X	Allergy patch tests	977	0.63	$33.30	$12.66	$6.66
95052	X	Photo patch test	977	0.63	$33.30	$12.66	$6.66
95056	X	Photosensitivity tests	977	0.63	$33.30	$12.66	$6.66
95060	X	Eye allergy tests	977	0.63	$33.30	$12.66	$6.66
95065	X	Nose allergy test	977	0.63	$33.30	$12.66	$6.66
95070	S	Bronchial allergy tests	973	1.89	$99.90	$55.82	$19.98
95071	S	Bronchial allergy tests	973	1.89	$99.90	$55.82	$19.98
95075	X	Ingestion challenge test	928	3.11	$164.55	$83.85	$32.91
95078	X	Provocative testing	977	0.63	$33.30	$12.66	$6.66
95115	X	Immunotherapy, one injection	978	0.31	$16.65	$3.39	$3.33
95117	X	Immunotherapy injections	978	0.31	$16.65	$3.39	$3.33
95120	E	Immunotherapy, one injection	.....	.....	.....	.....	.....
95125	E	Immunotherapy, many antigens	.....	.....	.....	.....	.....
95130	E	Immunotherapy, insect venom	.....	.....	.....	.....	.....
95131	E	Immunotherapy, insect venoms	.....	.....	.....	.....	.....

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
95132	E	Immunotherapy, insect venoms	.....	.....	.....	.....	.....
95133	E	Immunotherapy, insect venoms	.....	.....	.....	.....	.....
95134	E	Immunotherapy, insect venoms	.....	.....	.....	.....	.....
95144	X	Antigen therapy services	978	0.31	$16.65	$3.39	$3.33
95145	X	Antigen therapy services	978	0.31	$16.65	$3.39	$3.33
95146	X	Antigen therapy services	978	0.31	$16.65	$3.39	$3.33
95147	X	Antigen therapy services	978	0.31	$16.65	$3.39	$3.33
95148	X	Antigen therapy services	978	0.31	$16.65	$3.39	$3.33
95149	X	Antigen therapy services	901	0.07	$3.92	$2.49	$.78
95165	X	Antigen therapy services	978	0.31	$16.65	$3.39	$3.33
95170	X	Antigen therapy services	901	0.07	$3.92	$2.49	$.78
95180	X	Rapid desensitization	977	0.63	$33.30	$12.66	$6.66
95199	X	Allergy immunology services	977	0.63	$33.30	$12.66	$6.66
95805	S	Multiple sleep latency test	979	10.17	$537.72	$288.83	$107.54
95806	S	Sleep study, unattended	979	10.17	$537.72	$288.83	$107.54
95807	S	Sleep study, attended	979	10.17	$537.72	$288.83	$107.54
95808	S	Polysomnography, 1–3	979	10.17	$537.72	$288.83	$107.54
95810	S	Polysomnography, 4 or more	979	10.17	$537.72	$288.83	$107.54
95811	S	Polysomnography w/cpap	979	10.17	$537.72	$288.83	$107.54
95812	S	Electroencephalogram (EEG)	979	10.17	$537.72	$288.83	$107.54
95813	S	Electroencephalogram (EEG)	979	10.17	$537.72	$288.83	$107.54
95816	X	Electroencephalogram (EEG)	980	2.15	$113.62	$57.86	$22.72
95819	X	Electroencephalogram (EEG)	980	2.15	$113.62	$57.86	$22.72
95822	X	Sleep electroencephalogram	980	2.15	$113.62	$57.86	$22.72
95824	X	Electroencephalography	980	2.15	$113.62	$57.86	$22.72
95827	S	Night electroencephalogram	979	10.17	$537.72	$288.83	$107.54
95829	X	Surgery electrocorticogram	980	2.15	$113.62	$57.86	$22.72
95830	N	Insert electrodes for EEG	.....	.....	.....	.....	.....
95831	N	Limb muscle testing, manual	.....	.....	.....	.....	.....
95832	N	Hand muscle testing, manual	.....	.....	.....	.....	.....
95833	N	Body muscle testing, manual	.....	.....	.....	.....	.....
95834	N	Body muscle testing, manual	.....	.....	.....	.....	.....
95851	N	Range of motion measurements	.....	.....	.....	.....	.....
95852	N	Range of motion measurements	.....	.....	.....	.....	.....
95857	X	Tensilon test	981	1.46	$77.38	$41.81	$15.48
95858	X	Tensilon test & myogram	982	1.39	$73.46	$38.87	$14.69
95860	X	Muscle test, one limb	982	1.39	$73.46	$38.87	$14.69
95861	X	Muscle test, two limbs	982	1.39	$73.46	$38.87	$14.69
95863	X	Muscle test, 3 limbs	982	1.39	$73.46	$38.87	$14.69
95864	X	Muscle test, 4 limbs	982	1.39	$73.46	$38.87	$14.69
95867	X	Muscle test, head or neck	981	1.46	$77.38	$41.81	$15.48
95868	X	Muscle test, head or neck	982	1.39	$73.46	$38.87	$14.69
95869	X	Muscle test, thor paraspinal	981	1.46	$77.38	$41.81	$15.48
95870	X	Muscle test, non-paraspinal	981	1.46	$77.38	$41.81	$15.48
95872	X	Muscle test, one fiber	982	1.39	$73.46	$38.87	$14.69
95875	X	Limb exercise test	982	1.39	$73.46	$38.87	$14.69
95900	X	Motor nerve conduction test	981	1.46	$77.38	$41.81	$15.48
95903	X	Motor nerve conduction test	982	1.39	$73.46	$38.87	$14.69
95904	X	Sense nerve conduction test	982	1.39	$73.46	$38.87	$14.69
95920	C	Intraoperative nerve testing	.....	.....	.....	.....	.....
95921	X	Autonomic nervous func test	981	1.46	$77.38	$41.81	$15.48
95922	X	Autonomic nervous func test	981	1.46	$77.38	$41.81	$15.48
95923	X	Autonomic nervous func test	981	1.46	$77.38	$41.81	$15.48
95925	X	Somatosensory testing	982	1.39	$73.46	$38.87	$14.69
95926	X	Somatosensory testing	981	1.46	$77.38	$41.81	$15.48
95927	X	Somatosensory testing	981	1.46	$77.38	$41.81	$15.48
95930	X	Visual evoked potential test	981	1.46	$77.38	$41.81	$15.48
95933	X	Blink reflex test	981	1.46	$77.38	$41.81	$15.48
95934	X	'h' reflex test	981	1.46	$77.38	$41.81	$15.48
95936	X	'h' reflex test	981	1.46	$77.38	$41.81	$15.48
95937	X	Neuromuscular junction test	981	1.46	$77.38	$41.81	$15.48
95950	X	Ambulatory eeg monitoring	981	1.46	$77.38	$41.81	$15.48
95951	S	EEG monitoring/videorecord	979	10.17	$537.72	$288.83	$107.54
95953	S	EEG monitoring/computer	979	10.17	$537.72	$288.83	$107.54
95954	S	EEG monitoring/giving drugs	979	10.17	$537.72	$288.83	$107.54
95955	X	EEG during surgery	980	2.15	$113.62	$57.86	$22.72
95956	N	EEG monitoring/cable/radio	.....	.....	.....	.....	.....
95957	N	EEG digital analysis	.....	.....	.....	.....	.....
95958	S	EEG monitoring/function test	979	10.17	$537.72	$288.83	$107.54
95961	C	Electrode stimulation, brain	.....	.....	.....	.....	.....
95962	C	Electrode stimulation, brain	.....	.....	.....	.....	.....
95999	N	Neurological procedure	.....	.....	.....	.....	.....
96100	X	Psychological testing	089	2.54	$134.19	$37.29	$26.84
96105	X	Assessment of aphasia	089	2.54	$134.19	$37.29	$26.84
96110	X	Developmental test, lim	089	2.54	$134.19	$37.29	$26.84

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
96111	X	Developmental test, extend	089	2.54	$134.19	$37.29	$26.84
96115	X	Neurobehavior status exam	089	2.54	$134.19	$37.29	$26.84
96117	X	Neuropsych test battery	089	2.54	$134.19	$37.29	$26.84
96400	S	Chemotherapy, (SC)/(IM)	987	0.65	$34.28	$13.33	$6.86
96405	S	Intralesional chemo admin	987	0.65	$34.28	$13.33	$6.86
96406	S	Intralesional chemo admin	987	0.65	$34.28	$13.33	$6.86
96408	S	Chemotherapy, push technique	988	4.15	$219.40	$97.63	$43.88
96410	S	Chemotherapy, infusion method	988	4.15	$219.40	$97.63	$43.88
96412	S	Chemotherapy, infusion method	988	4.15	$219.40	$97.63	$43.88
96414	S	Chemotherapy, infusion method	989	1.72	$91.09	$40.68	$18.22
96420	S	Chemotherapy, push technique	988	4.15	$219.40	$97.63	$43.88
96422	S	Chemotherapy, infusion method	988	4.15	$219.40	$97.63	$43.88
96423	S	Chemotherapy, infusion method	988	4.15	$219.40	$97.63	$43.88
96425	S	Chemotherapy, infusion method	989	1.72	$91.09	$40.68	$18.22
96440	S	Chemotherapy, intracavitary	989	1.72	$91.09	$40.68	$18.22
96445	S	Chemotherapy, intracavitary	989	1.72	$91.09	$40.68	$18.22
96450	S	Chemotherapy, into CNS	989	1.72	$91.09	$40.68	$18.22
96520	E	Pump refilling, maintenance					
96530	E	Pump refilling, maintenance					
96542	S	Chemotherapy injection	989	1.72	$91.09	$40.68	$18.22
96545	N	Provide chemotherapy agent					
96549	S	Chemotherapy, unspecified	987	0.65	$34.28	$13.33	$6.86
96900	S	Ultraviolet light therapy	990	0.43	$22.53	$8.14	$4.51
96902	N	Trichogram					
96910	S	Photochemotherapy with UV–B	990	0.43	$22.53	$8.14	$4.51
96912	S	Photochemotherapy with UV–A	990	0.43	$22.53	$8.14	$4.51
96913	S	Photochemotherapy, UV–A or B	990	0.43	$22.53	$8.14	$4.51
96999	S	Dermatological procedure	990	0.43	$22.53	$8.14	$4.51
97001	A	Pt evaluation					
97002	A	Pt re-evaluation					
97003	A	Ot evaluation					
97004	A	Ot re-evaluation					
97010	A	Hot or cold packs therapy					
97012	A	Mechanical traction therapy					
97014	A	Electric stimulation therapy					
97016	A	Vasopneumatic device therapy					
97018	A	Paraffin bath therapy					
97020	A	Microwave therapy					
97022	A	Whirlpool therapy					
97024	A	Diathermy treatment					
97026	A	Infrared therapy					
97028	A	Ultraviolet therapy					
97032	A	Electrical stimulation					
97033	A	Electric current therapy					
97034	A	Contrast bath therapy					
97035	A	Ultrasound therapy					
97036	A	Hydrotherapy					
97039	A	Physical therapy treatment					
97110	A	Therapeutic exercises					
97112	A	Neuromuscular reeducation					
97113	A	Aquatic therapy/exercises					
97116	A	Gait training therapy					
97122	A	Manual traction therapy					
97124	A	Massage therapy					
97139	A	Physical medicine procedure					
97150	A	Group therapeutic procedures					
97250	S	Myofascial release	997	0.69	$36.24	$7.25	$7.25
97260	S	Regional manipulation	997	0.69	$36.24	$7.25	$7.25
97261	S	Supplemental manipulations	997	0.69	$36.24	$7.25	$7.25
97265	A	Joint mobilization					
97504	A	Orthotic training					
97520	A	Prosthetic training					
97530	A	Therapeutic activities					
97535	A	Self care mngment training					
97537	A	Community/work reintegration					
97542	A	Wheelchair mngement training					
97545	A	Work hardening					
97546	A	Work hardening					
97703	A	Prosthetic checkout					
97750	A	Physical performance test					
97770	A	Cognitive skills development					
97780	E	Acupuncture w/o stim					
97781	E	Acupuncture w/stim					
97799	A	Physical medicine procedure					
98925	S	Osteopathic manipulation	997	0.69	$36.24	$7.25	$7.25

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
98926	S	Osteopathic manipulation	997	0.69	$36.24	$7.25	$7.25
98927	S	Osteopathic manipulation	997	0.69	$36.24	$7.25	$7.25
98928	S	Osteopathic manipulation	997	0.69	$36.24	$7.25	$7.25
98929	S	Osteopathic manipulation	997	0.69	$36.24	$7.25	$7.25
98940	S	Chiropractic manipulation	997	0.69	$36.24	$7.25	$7.25
98941	S	Chiropractic manipulation	997	0.69	$36.24	$7.25	$7.25
98942	S	Chiropractic manipulation	997	0.69	$36.24	$7.25	$7.25
98943	E	Chiropractic manipulation					
99000	E	Specimen handling					
99001	N	Specimen handling					
99002	E	Device handling					
99024	N	Post-op follow-up visit					
99025	N	Initial surgical evaluation					
99050	E	Medical services after hrs					
99052	E	Medical services at night					
99054	E	Medical services, unusual hrs					
99056	E	Non-office medical services					
99058	N	Office emergency care					
99070	E	Special supplies					
99071	E	Patient education materials					
99075	E	Medical testimony					
99078	S	Group health education	921				
99080	E	Special reports or forms					
99082	E	Unusual physician travel					
99090	E	Computer data analysis					
99100	N	Special anesthesia service					
99116	N	Anesthesia with hypothermia					
99135	N	Special anesthesia procedure					
99140	N	Emergency anesthesia					
99141	N	Sedation, iv/im or inhalant					
99142	N	Sedation, oral/rectal/nasal					
99175	N	Induction of vomiting					
99183	S	Hyperbaric oxygen therapy	969	2.65	$140.06	$141.70	$28.01
99185	N	Regional hypothermia					
99186	N	Total body hypothermia					
99190	C	Special pump services					
99191	C	Special pump services					
99192	C	Special pump services					
99195	X	Phlebotomy	999	0.43	$22.53	$10.85	$4.51
99199	N	Special service or report					
99201	V	Office/outpatient visit, new	911				
99202	V	Office/outpatient visit, new	911				
99203	V	Office/outpatient visit, new	913				
99204	V	Office/outpatient visit, new	915				
99205	V	Office/outpatient visit, new	915				
99211	V	Office/outpatient visit, est	911				
99212	V	Office/outpatient visit, est	911				
99213	V	Office/outpatient visit, est	913				
99214	V	Office/outpatient visit, est	915				
99215	V	Office/outpatient visit, est	915				
99217	N	Observation care discharge					
99218	N	Observation care					
99219	N	Observation care					
99220	N	Observation care					
99221	E	Initial hospital care					
99222	E	Initial hospital care					
99223	E	Initial hospital care					
99231	E	Subsequent hospital care					
99232	E	Subsequent hospital care					
99233	E	Subsequent hospital care					
99234	C	Observ/hosp same date					
99235	C	Observ/hosp same date					
99236	C	Observ/hosp same date					
99238	E	Hospital discharge day					
99239	E	Hospital discharge day					
99241	V	Office consultation	911				
99242	V	Office consultation	911				
99243	V	Office consultation	913				
99244	V	Office consultation	915				
99245	V	Office consultation	915				
99251	C	Initial inpatient consult					
99252	C	Initial inpatient consult					
99253	C	Initial inpatient consult					
99254	C	Initial inpatient consult					
99255	C	Initial inpatient consult					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
99261	C	Follow-up inpatient consult					
99262	C	Follow-up inpatient consult					
99263	C	Follow-up inpatient consult					
99271	V	Confirmatory consultation	911				
99272	V	Confirmatory consultation	911				
99273	V	Confirmatory consultation	913				
99274	V	Confirmatory consultation	915				
99275	V	Confirmatory consultation	915				
99281	V	Emergency dept visit	951				
99282	V	Emergency dept visit	951				
99283	V	Emergency dept visit	953				
99284	V	Emergency dept visit	955				
99285	V	Emergency dept visit	955				
99288	E	Direct advanced life support					
99291	S	Critical care, first hour	900	7.44	$393.74	$144.87	$78.75
99292	N	Critical care, addl 30 min					
99295	C	Neonatal critical care					
99296	C	Neonatal critical care					
99297	C	Neonatal critical care					
99301	E	Nursing facility care					
99302	E	Nursing facility care					
99303	E	Nursing facility care					
99311	E	Nursing facility care, subseq					
99312	E	Nursing facility care, subseq					
99313	E	Nursing facility care, subseq					
99315	E	Nursing fac discharge day					
99316	E	Nursing fac discharge day					
99321	N	Rest home visit, new patient					
99322	N	Rest home visit, new patient					
99323	N	Rest home visit, new patient					
99331	N	Rest home visit, estab pat					
99332	N	Rest home visit, estab pat					
99333	N	Rest home visit, estab pat					
99341	N	Home visit, new patient					
99342	N	Home visit, new patient					
99343	N	Home visit, new patient					
99344	N	Home visit, new patient					
99345	N	Home visit, new patient					
99347	N	Home visit, estab patient					
99348	N	Home visit, estab patient					
99349	N	Home visit, estab patient					
99350	N	Home visit, estab patient					
99354	N	Prolonged service, office					
99355	N	Prolonged service, office					
99356	C	Prolonged service, inpatient					
99357	C	Prolonged service, inpatient					
99358	N	Prolonged serv, w/o contact					
99359	N	Prolonged serv, w/o contact					
99360	E	Physician standby services					
99361	E	Physician/team conference					
99362	E	Physician/team conference					
99371	E	Physician phone consultation					
99372	E	Physician phone consultation					
99373	E	Physician phone consultation					
99374	E	Home health care supervision					
99375	E	Home health care supervision					
99377	E	Hospice care supervision					
99378	E	Hospice care supervision					
99379	E	Nursing fac care supervision					
99380	E	Nursing fac care supervision					
99381	E	Preventive visit, new, infant					
99382	E	Preventive visit, new, age 1–4					
99383	E	Preventive visit, new, age 5–11					
99384	E	Preventive visit, new, 12–17					
99385	E	Preventive visit, new, 18–39					
99386	E	Preventive visit, new, 40–64					
99387	E	Preventive visit, new, 65 & over					
99391	E	Preventive visit, est, infant					
99392	E	Preventive visit, est, age 1–4					
99393	E	Preventive visit, est, age 5–11					
99394	E	Preventive visit, est, 12–17					
99395	E	Preventive visit, est, 18–39					
99396	E	Preventive visit, est, 40–64					
99397	E	Preventive visit, est, 65 & over					
99401	E	Preventive counseling, indiv					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
99402	E	Preventive counseling, indiv					
99403	E	Preventive counseling, indiv					
99404	E	Preventive counseling, indiv					
99411	E	Preventive counseling, group					
99412	E	Preventive counseling, group					
99420	E	Health risk assessment test					
99429	E	Unlisted preventive service					
99431	N	Initial care, normal newborn					
99432	N	Newborn care not in hospital					
99433	C	Normal newborn care, hospital					
99435	E	Hospital NB discharge day					
99436	N	Attendance, birth					
99440	S	Newborn resuscitation	947	4.07	$215.48	$109.61	$43.10
99450	E	Life/disability evaluation					
99455	N	Disability examination					
99456	N	Disability examination					
99499	N	Unlisted E/M service					
A0021	E	Outside state ambulance serv					
A0030	A	Air ambulance service					
A0040	A	Helicopter ambulance service					
A0050	A	Water amb service emergency					
A0080	E	Noninterest escort in non er					
A0090	E	Interest escort in non er					
A0100	E	Nonemergency transport taxi					
A0110	E	Nonemergency transport bus					
A0120	E	Noner transport mini-bus					
A0130	E	Noner transport wheelch van					
A0140	E	Nonemergency transport air					
A0160	E	Noner transport case worker					
A0170	E	Noner transport parking fees					
A0180	E	Noner transport lodgng recip					
A0190	E	Noner transport meals recip					
A0200	E	Noner transport lodgng escrt					
A0210	E	Noner transport meals escort					
A0225	A	Neonatal emergency transport					
A0300	A	Ambulance basic non-emer all					
A0302	A	Ambulance basic emergeny all					
A0304	A	Amb adv non-er no serv all					
A0306	A	Amb adv non-er spec serv all					
A0308	A	Amb adv er no spec serv all					
A0310	A	Amb adv er spec serv all					
A0320	A	Amb basic non-er + supplies					
A0322	A	Amb basic emerg + supplies					
A0324	A	Adv non-er serv sep mileage					
A0326	A	Adv non-er no serv sep mile					
A0328	A	Adv er no serv sep mileage					
A0330	A	Adv er spec serv sep mile					
A0340	A	Amb basic non-er + mileage					
A0342	A	Ambul basic emer + mileage					
A0344	A	Amb adv non-er no serv +mile					
A0346	A	Amb adv non-er serv + mile					
A0348	A	Adv emer no spec serv + mile					
A0350	A	Adv emer spec serv + mileage					
A0360	A	Basic non-er sep mile & supp					
A0362	A	Basic emer sep mile & supply					
A0364	A	Adv non-er no serv sep mi & su					
A0366	A	Adv non-er serv sep mil & supp					
A0368	A	Adv er no serv sep mile & supp					
A0370	A	Adv er spec serv sep mi & supp					
A0380	A	Basic life support mileage					
A0382	A	Basic support routine suppls					
A0384	A	Bls defibrillation supplies					
A0390	A	Advanced life support mileage					
A0392	A	Als defibrillation supplies					
A0394	A	Als IV drug therapy supplies					
A0396	A	Als esophageal intub suppls					
A0398	A	Als routine disposble suppls					
A0420	A	Ambulance waiting 1/2 hr					
A0422	A	Ambulance 02 life sustaining					
A0424	A	Extra ambulance attendant					
A0888	E	Noncovered ambulance mileage					
A0999	A	Unlisted ambulance service					
A4206	A	1 CC sterile syringe & needle					
A4207	A	2 CC sterile syringe & needle					
A4208	A	3 CC sterile syringe & needle					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
A4209	A	5+ CC sterile syringe & needle					
A4210	E	Nonneedle injection device					
A4211	A	Supp for self-adm injections					
A4212	A	Non coring needle or stylet					
A4213	A	20+ CC syringe only					
A4214	A	30 CC sterile water/saline					
A4215	A	Sterile needle					
A4220	A	Infusion pump refill kit					
A4221	A	Maint drug infus cath per wk					
A4222	A	Drug infusion pump supplies					
A4230	E	Infus insulin pump non needl					
A4231	E	Infusion insulin pump needle					
A4232	E	Syringe w/needle insulin 3cc					
A4244	A	Alcohol or peroxide per pint					
A4245	A	Alcohol wipes per box					
A4246	A	Betadine/phisohex solution					
A4247	A	Betadine/iodine swabs/wipes					
A4250	E	Urine reagent strips/tablets					
A4253	A	Blood glucose/reagent strips					
A4254	A	Battery for glucose monitor					
A4255	A	Glucose monitor platforms					
A4256	A	Calibrator solution/chips					
A4258	A	Lancet device each					
A4259	A	Lancets per box					
A4260	E	Levonorgestrel implant					
A4262	N	Temporary tear duct plug					
A4263	A	Permanent tear duct plug					
A4265	A	Paraffin					
A4270	A	Disposable endoscope sheath					
A4300	A	Cath impl vasc access portal					
A4301	A	Implantable access syst perc					
A4305	A	Drug delivery system >=50 ML					
A4306	A	Drug delivery system <=5 ML					
A4310	A	Insert tray w/o bag/cath					
A4311	A	Catheter w/o bag 2-way latex					
A4312	A	Cath w/o bag 2-way silicone					
A4313	A	Catheter w/bag 3-way					
A4314	A	Cath w/drainage 2-way latex					
A4315	A	Cath w/drainage 2-way silcne					
A4316	A	Cath w/drainage 3-way					
A4320	A	Irrigation tray					
A4321	A	Cath therapeutic irrig agent					
A4322	A	Irrigation syringe					
A4323	A	Saline irrigation solution					
A4326	A	Male external catheter					
A4327	A	Fem urinary collect dev cup					
A4328	A	Fem urinary collect pouch					
A4329	A	External catheter start set					
A4330	A	Stool collection pouch					
A4335	A	Incontinence supply					
A4338	A	Indwelling catheter latex					
A4340	A	Indwelling catheter special					
A4344	A	Cath indw foley 2 way silicn					
A4346	A	Cath indw foley 3 way					
A4347	A	Male external catheter					
A4351	A	Straight tip urine catheter					
A4352	A	Coude tip urinary catheter					
A4353	A	Intermittent urinary cath					
A4354	A	Cath insertion tray w/bag					
A4355	A	Bladder irrigation tubing					
A4356	A	Ext ureth clmp or compr dvc					
A4357	A	Bedside drainage bag					
A4358	A	Urinary leg bag					
A4359	A	Urinary suspensory w/o leg b					
A4361	A	Ostomy face plate					
A4362	A	Solid skin barrier					
A4363	A	Liquid skin barrier					
A4364	A	Ostomy/cath adhesive					
A4365	A	Ostomy adhesive remover wipe					
A4367	A	Ostomy belt					
A4368	A	Ostomy filter					
A4397	A	Irrigation supply sleeve					
A4398	A	Ostomy irrigation bag					
A4399	A	Ostomy irrig cone/cath w brs					
A4400	A	Ostomy irrigation set					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
A4402	A	Lubricant per ounce					
A4404	A	Ostomy ring each					
A4421	A	Ostomy supply misc					
A4454	A	Tape all types all sizes					
A4455	A	Adhesive remover per ounce					
A4460	A	Elastic compression bandage					
A4462	A	Abdmnl drssng holder/binder					
A4465	A	Non-elastic extremity binder					
A4470	A	Gravlee jet washer					
A4480	A	Vabra aspirator					
A4481	A	Tracheostoma filter					
A4490	E	Above knee surgical stocking					
A4495	E	Thigh length surg stocking					
A4500	E	Below knee surgical stocking					
A4510	E	Full length surg stocking					
A4550	E	Surgical trays					
A4554	E	Disposable underpads					
A4556	A	Electrodes					
A4557	A	Lead wires					
A4558	A	Conductive paste or gel					
A4560	A	Pessary					
A4565	A	Slings					
A4570	A	Splint					
A4572	A	Rib belt					
A4575	E	Hyperbaric o2 chamber disps					
A4580	A	Cast supplies (plaster)					
A4590	A	Special casting material					
A4595	A	TENS suppl 2 lead per month					
A4611	A	Heavy duty battery					
A4612	A	Battery cables					
A4613	A	Battery charger					
A4615	A	Cannula nasal					
A4616	A	Tubing (oxygen) per foot					
A4617	A	Mouth piece					
A4618	A	Breathing circuits					
A4619	A	Face tent					
A4620	A	Variable concentration mask					
A4621	A	Tracheotomy mask or collar					
A4622	A	Tracheostomy or larngectomy					
A4623	A	Tracheostomy inner cannula					
A4624	A	Tracheal suction tube					
A4625	A	Trach care kit for new trach					
A4626	A	Tracheostomy cleaning brush					
A4627	E	Spacer bag/reservoir					
A4628	A	Oropharyngeal suction cath					
A4629	A	Tracheostomy care kit					
A4630	A	Repl bat t.e.n.s. own by pt					
A4631	A	Wheelchair battery					
A4635	A	Underarm crutch pad					
A4636	A	Handgrip for cane etc					
A4637	A	Repl tip cane/crutch/walker					
A4640	A	Alternating pressure pad					
A4641	N	Diagnostic imaging agent					
A4642	N	Satumomab pendetide per dose					
A4643	N	High dose contrast MRI					
A4644	N	Contrast 100–199 MGs iodine					
A4645	N	Contrast 200–299 MGs iodine					
A4646	N	Contrast 300–399 MGs iodine					
A4647	N	Supp-paramagnetic contr mat					
A4649	A	Surgical supplies					
A4650	A	Supp esrd centrifuge					
A4655	A	Esrd syringe/needle					
A4660	A	Esrd blood pressure device					
A4663	A	Esrd blood pressure cuff					
A4670	E	Auto blood pressure monitor					
A4680	A	Activated carbon filters					
A4690	A	Dialyzers					
A4700	A	Standard dialysate solution					
A4705	A	Bicarb dialysate solution					
A4712	A	Sterile water					
A4714	A	Treated water for dialysis					
A4730	A	Fistula cannulation set dial					
A4735	A	Local/topical anesthetics					
A4740	A	Esrd shunt accessory					
A4750	A	Arterial or venous tubing					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
A4755	A	Arterial and venous tubing					
A4760	A	Standard testing solution					
A4765	A	Dialysate concentrate					
A4770	A	Blood testing supplies					
A4771	A	Blood clotting time tube					
A4772	A	Dextrostick/glucose strips					
A4773	A	Hemostix					
A4774	A	Ammonia test paper					
A4780	A	Esrd sterilizing agent					
A4790	A	Esrd cleansing agents					
A4800	A	Heparin/antidote dialysis					
A4820	A	Supplies hemodialysis kit					
A4850	A	Rubber tipped hemostats					
A4860	A	Disposable catheter caps					
A4870	A	Plumbing/electrical work					
A4880	A	Water storage tanks					
A4890	A	Contracts/repair/maintenance					
A4900	A	Capd supply kit					
A4901	A	Capd supply kit					
A4905	A	Ipd supply kit					
A4910	A	Esrd nonmedical supplies					
A4912	A	Gomco drain bottle					
A4913	A	Esrd supply					
A4914	A	Preparation kit					
A4918	A	Venous pressure clamp					
A4919	A	Supp dialysis dialyzer holde					
A4920	A	Harvard pressure clamp					
A4921	A	Measuring cylinder					
A4927	A	Gloves					
A5051	A	Pouch clsd w barr attached					
A5052	A	Clsd ostomy pouch w/o barr					
A5053	A	Clsd ostomy pouch faceplate					
A5054	A	Clsd ostomy pouch w/flange					
A5055	A	Stoma cap					
A5061	A	Pouch drainable w barrier at					
A5062	A	Drnble ostomy pouch w/o barr					
A5063	A	Drain ostomy pouch w/flange					
A5064	E	Drain ostomy pouch w/fceplte					
A5065	E	Drain ostomy pouch on fcplte					
A5071	A	Urinary pouch w/barrier					
A5072	A	Urinary pouch w/o barrier					
A5073	A	Urinary pouch on barr w/flng					
A5074	E	Urinary pouch w/faceplate					
A5075	E	Urinary pouch on faceplate					
A5081	A	Continent stoma plug					
A5082	A	Continent stoma catheter					
A5093	A	Ostomy accessory convex inse					
A5102	A	Bedside drain btl w/wo tube					
A5105	A	Urinary suspensory					
A5112	A	Urinary leg bag					
A5113	A	Latex leg strap					
A5114	A	Foam/fabric leg strap					
A5119	A	Skin barrier wipes box pr 50					
A5121	A	Solid skin barrier 6x6					
A5122	A	Solid skin barrier 8x8					
A5123	A	Skin barrier with flange					
A5126	A	Adhesive disc/foam pad					
A5131	A	Appliance cleaner					
A5149	A	Incontinence/ostomy supply					
A5500	A	Diab shoe for density insert					
A5501	A	Diabetic custom molded shoe					
A5502	A	Diabetic shoe density insert					
A5503	A	Diabetic shoe w/roller/rockr					
A5504	A	Diabetic shoe with wedge					
A5505	A	Diab shoe w/metatarsal bar					
A5506	A	Diabetic shoe w/off set heel					
A5507	A	Modification diabetic shoe					
A6020	A	Collagen dressing cover ea					
A6025	E	Silicone gel sheet, each					
A6154	A	Wound pouch each					
A6196	A	Alginate dressing <=16 sq in					
A6197	A	Alginate drsg >16 <=48 sq in					
A6198	A	Alginate dressing > 48 sq in					
A6199	A	Alginate drsg wound filler					
A6203	A	Composite drsg <= 16 sq in					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
A6204	A	Composite drsg >16<=48 sq in					
A6205	A	Composite drsg > 48 sq in					
A6206	A	Contact layer <= 16 sq in					
A6207	A	Contact layer >16<= 48 sq in					
A6208	A	Contact layer > 48 sq in					
A6209	A	Foam drsg <=16 sq in w/o bdr					
A6210	A	Foam drg >16<=48 sq in w/o b					
A6211	A	Foam drg > 48 sq in w/o brdr					
A6212	A	Foam drg <=16 sq in w/border					
A6213	A	Foam drg >16<=48 sq in w/bdr					
A6214	A	Foam drg > 48 sq in w/border					
A6215	A	Foam dressing wound filler					
A6216	A	Non-sterile gauze<=16 sq in					
A6217	A	Non-sterile gauze>16<=48 sq					
A6218	A	Non-sterile gauze > 48 sq in					
A6219	A	Gauze <= 16 sq in w/border					
A6220	A	Gauze >16 <=48 sq in w/bordr					
A6221	A	Gauze > 48 sq in w/border					
A6222	A	Gauze <=16 in no w/sal w/o b					
A6223	A	Gauze >16<=48 no w/sal w/o b					
A6224	A	Gauze > 48 in no w/sal w/o b					
A6228	A	Gauze <= 16 sq in water/sal					
A6229	A	Gauze >16<=48 sq in watr/sal					
A6230	A	Gauze > 48 sq in water/salne					
A6234	A	Hydrocolld drg <=16 w/o bdr					
A6235	A	Hydrocolld drg >16<=48 w/o b					
A6236	A	Hydrocolld drg > 48 in w/o b					
A6237	A	Hydrocolld drg <=16 in w/bdr					
A6238	A	Hydrocolld drg >16<=48 w/bdr					
A6239	A	Hydrocolld drg > 48 in w/bdr					
A6240	A	Hydrocolld drg filler paste					
A6241	A	Hydrocolloid drg filler dry					
A6242	A	Hydrogel drg <=16 in w/o bdr					
A6243	A	Hydrogel drg >16<=48 w/o bdr					
A6244	A	Hydrogel drg >48 in w/o bdr					
A6245	A	Hydrogel drg <= 16 in w/bdr					
A6246	A	Hydrogel drg >16<=48 in w/b					
A6247	A	Hydrogel drg > 48 sq in w/b					
A6248	A	Hydrogel drsg gel filler					
A6250	A	Skin seal protect moisturizr					
A6251	A	Absorpt drg <=16 sq in w/o b					
A6252	A	Absorpt drg >16 <=48 w/o bdr					
A6253	A	Absorpt drg > 48 sq in w/o b					
A6254	A	Absorpt drg <=16 sq in w/bdr					
A6255	A	Absorpt drg >16<=48 in w/bdr					
A6256	A	Absorpt drg > 48 sq in w/bdr					
A6257	A	Transparent film <= 16 sq in					
A6258	A	Transparent film >16<=48 in					
A6259	A	Transparent film > 48 sq in					
A6260	A	Wound cleanser any type/size					
A6261	A	Wound filler gel/paste/oz					
A6262	A	Wound filler dry form/gram					
A6263	A	Non-sterile elastic gauze/yd					
A6264	A	Non-sterile no elastic gauze					
A6265	A	Tape per 18 sq inches					
A6266	A	Impreg gauze no h20/sal/yard					
A6402	A	Sterile gauze <= 16 sq in					
A6403	A	Sterile gauze>16 <= 48 sq in					
A6404	A	Sterile gauze > 48 sq in					
A6405	A	Sterile elastic gauze/yd					
A6406	A	Sterile non-elastic gauze/yd					
A9150	E	Misc/exper non-prescript dru					
A9160	E	Podiatrist non-covered servi					
A9170	E	Chiropractor non-covered ser					
A9190	E	Misc/expe personal comfort i					
A9270	E	Non-covered item or service					
A9300	E	Exercise equipment					
A9500	N	Technetium TC 99m sestamibi					
A9502	N	Technetium TC99M tetrofosmin					
A9503	N	Technetium TC 99m medronate					
A9505	N	Thallous chloride TL 201/mci					
A9600	N	Strontium-89 chloride					
B4034	A	Enter feed supkit syr by day					
B4035	A	Enteral feed supp pump per d					
B4036	A	Enteral feed sup kit grav by					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
B4081	A	Enteral ng tubing w/ stylet					
B4082	A	Enteral ng tubing w/o stylet					
B4083	A	Enteral stomach tube levine					
B4084	A	Gastrostomy/jejunostomy tubi					
B4085	A	Gastrostomy tube w/ring each					
B4150	A	Enteral formulae category i					
B4151	A	Enteral formulae category i–					
B4152	A	Enteral formulae category ii					
B4153	A	Enteral formulae category ii					
B4154	A	Enteral formulae category IV					
B4155	A	Enteral formulae category v					
B4156	A	Enteral formulae category vi					
B4164	A	Parenteral 50% dextrose solu					
B4168	A	Parenteral sol amino acid 3.					
B4172	A	Parenteral sol amino acid 5.					
B4176	A	Parenteral sol amino acid 7–					
B4178	A	Parenteral sol amino acid >					
B4180	A	Parenteral sol carb > 50%					
B4184	A	Parenteral sol lipids 10%					
B4186	A	Parenteral sol lipids 20%					
B4189	A	Parenteral sol amino acid &					
B4193	A	Parenteral sol 52–73 gm prot					
B4197	A	Parenteral sol 74–100 gm pro					
B4199	A	Parenteral sol > 100gm prote					
B4216	A	Parenteral nutrition additiv					
B4220	A	Parenteral supply kit premix					
B4222	A	Parenteral supply kit homemi					
B4224	A	Parenteral administration ki					
B5000	A	Parenteral sol renal-amirosy					
B5100	A	Parenteral sol hepatic-fream					
B5200	A	Parenteral sol stres-brnch c					
B9000	A	Enter infusion pump w/o alrm					
B9002	A	Enteral infusion pump w/ ala					
B9004	A	Parenteral infus pump portab					
B9006	A	Parenteral infus pump statio					
B9998	A	Enteral supp not otherwise c					
B9999	A	Parenteral supp not othrws c					
D0120	E	Periodic oral evaluation					
D0140	E	Limit oral eval problm focus					
D0150	S	Comprehensve oral evaluation	031	1.33	$70.52	$14.10	$14.10
D0160	E	Extensv oral eval prob focus					
D0210	E	Intraor complete film series					
D0220	E	Intraoral periapical first f					
D0230	E	Intraoral periapical ea add					
D0240	S	Intraoral occlusal film	031	1.33	$70.52	$14.10	$14.10
D0250	S	Extraoral first film	031	1.33	$70.52	$14.10	$14.10
D0260	S	Extraoral ea additional film	031	1.33	$70.52	$14.10	$14.10
D0270	S	Dental bitewing single film	031	1.33	$70.52	$14.10	$14.10
D0272	S	Dental bitewings two films	031	1.33	$70.52	$14.10	$14.10
D0274	S	Dental bitewings four films	031	1.33	$70.52	$14.10	$14.10
D0290	E	Dental film skull/facial bon					
D0310	E	Dental saliography					
D0320	E	Dental tmj arthrogram incl i					
D0321	E	Dental other tmj films					
D0322	E	Dental tomographic survey					
D0330	E	Dental panoramic film					
D0340	E	Dental cephalometric film					
D0415	E	Bacteriologic study					
D0425	E	Caries susceptibility test					
D0460	S	Pulp vitality test	031	1.33	$70.52	$14.10	$14.10
D0470	E	Diagnostic casts					
D0471	S	Diagnostic photographs	031	1.33	$70.52	$14.10	$14.10
D0501	S	Histopathologic examinations	031	1.33	$70.52	$14.10	$14.10
D0502	S	Other oral pathology procedu	031	1.33	$70.52	$14.10	$14.10
D0999	S	Unspecified diagnostic proce	031	1.33	$70.52	$14.10	$14.10
D1110	E	Dental prophylaxis adult					
D1120	E	Dental prophylaxis child					
D1201	E	Topical fluor w prophy child					
D1203	E	Topical fluor w/o prophy chi					
D1204	E	Topical fluor w/o prophy adu					
D1205	E	Topical fluoride w/ prophy a					
D1310	E	Nutri counsel-control caries					
D1320	E	Tobacco counseling					
D1330	E	Oral hygiene instruction					
D1351	E	Dental sealant per tooth					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
D1510	S	Space maintainer fxd unilat	031	1.33	$70.52	$14.10	$14.10
D1515	S	Fixed bilat space maintainer	031	1.33	$70.52	$14.10	$14.10
D1520	S	Remove unilat space maintain	031	1.33	$70.52	$14.10	$14.10
D1525	S	Remove bilat space maintain	031	1.33	$70.52	$14.10	$14.10
D1550	S	Recement space maintainer	031	1.33	$70.52	$14.10	$14.10
D2110	E	Amalgam one surface primary					
D2120	E	Amalgam two surfaces primary					
D2130	E	Amalgam three surfaces prima					
D2131	E	Amalgam four/more surf prima					
D2140	E	Amalgam one surface permanen					
D2150	E	Amalgam two surfaces permane					
D2160	E	Amalgam three surfaces perma					
D2161	E	Amalgam 4 or > surfaces perm					
D2210	E	Silcate cement per restorat					
D2330	E	Resin one surface-anterior					
D2331	E	Resin two surfaces-anterior					
D2332	E	Resin three surfaces-anterio					
D2335	E	Resin 4/> surf or w incis an					
D2336	E	Composite resin crown					
D2380	E	Resin one surf poster primar					
D2381	E	Resin two surf poster primar					
D2382	E	Resin three/more surf post p					
D2385	E	Resin one surf poster perman					
D2386	E	Resin two surf poster perman					
D2387	E	Resin three/more surf post p					
D2410	E	Dental gold foil one surface					
D2420	E	Dental gold foil two surface					
D2430	E	Dental gold foil three surfa					
D2510	E	Dental inlay metalic 1 surf					
D2520	E	Dental inlay metallic 2 surf					
D2530	E	Dental inlay metl 3/more sur					
D2543	E	Dental onlay metallic 3 surf					
D2544	E	Dental onlay metl 4/more sur					
D2610	E	Inlay porcelain/ceramic 1 su					
D2620	E	Inlay porcelain/ceramic 2 su					
D2630	E	Dental onlay porc 3/more sur					
D2642	E	Dental onlay porcelin 2 surf					
D2643	E	Dental onlay porcelin 3 surf					
D2644	E	Dental onlay porc 4/more sur					
D2650	E	Inlay composite/resin one su					
D2651	E	Inlay composite/resin two su					
D2652	E	Dental inlay resin 3/mre sur					
D2662	E	Dental onlay resin 2 surface					
D2663	E	Dental onlay resin 3 surface					
D2664	E	Dental onlay resin 4/mre sur					
D2710	E	Crown resin laboratory					
D2720	E	Crown resin w/ high noble me					
D2721	E	Crown resin w/ base metal					
D2722	E	Crown resin w/ noble metal					
D2740	E	Crown porcelain/ceramic subs					
D2750	E	Crown porcelain w/ h noble m					
D2751	E	Crown porcelain fused base m					
D2752	E	Crown porcelain w/ noble met					
D2790	E	Crown full cast high noble m					
D2791	E	Crown full cast base metal					
D2792	E	Crown full cast noble metal					
D2810	E	Crown 3/4 cast metallic					
D2910	E	Dental recement inlay					
D2920	E	Dental recement crown					
D2930	E	Prefab stnlss steel crwn pri					
D2931	E	Prefab stnlss steel crown pe					
D2932	E	Prefabricated resin crown					
D2933	E	Prefab stainless steel crown					
D2940	E	Dental sedative filling					
D2950	E	Core build-up incl any pins					
D2951	E	Tooth pin retention					
D2952	E	Post and core cast + crown					
D2954	E	Prefab post/core + crown					
D2955	E	Post removal					
D2960	E	Laminate labial veneer					
D2961	E	Lab labial veneer resin					
D2962	E	Lab labial veneer porcelain					
D2970	S	Temporary-fractured tooth	031	1.33	$70.52	$14.10	$14.10
D2980	E	Crown repair					
D2999	S	Dental unspec restorative pr	031	1.33	$70.52	$14.10	$14.10

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
D3110	E	Pulp cap direct					
D3120	E	Pulp cap indirect					
D3220	E	Therapeutic pulpotomy					
D3230	E	Pulpal therapy anterior prim					
D3240	E	Pulpal therapy posterior pri					
D3310	E	Anterior					
D3320	E	Root canal therapy 2 canals					
D3330	E	Root canal therapy 3 canals					
D3346	E	Retreat root canal anterior					
D3347	E	Retreat root canal bicuspid					
D3348	E	Retreat root canal molar					
D3351	E	Apexification/recalc initial					
D3352	E	Apexification/recalc interim					
D3353	E	Apexification/recalc final					
D3410	E	Apicoect/perirad surg anter					
D3421	E	Root surgery bicuspid					
D3425	E	Root surgery molar					
D3426	E	Root surgery ea add root					
D3430	E	Retrograde filling					
D3450	E	Root amputation					
D3460	S	Endodontic endosseous implan	031	1.33	$70.52	$14.10	$14.10
D3470	E	Intentional replantation					
D3910	E	Isolation-tooth w rubb dam					
D3920	E	Tooth splitting					
D3950	E	Canal prep/fitting of dowel					
D3960	E	Bleaching of discolored toot					
D3999	S	Endodontic procedure	031	1.33	$70.52	$14.10	$14.10
D4210	E	Gingivectomy/plasty per quad					
D4211	E	Gingivectomy/plasty per toot					
D4220	E	Gingival curettage per quadr					
D4240	E	Gingival flap proc w/ planin					
D4249	E	Crown lengthen hard tissue					
D4250	S	Mucogingival surg per quadra	031	1.33	$70.52	$14.10	$14.10
D4260	S	Osseous surgery per quadrant	031	1.33	$70.52	$14.10	$14.10
D4263	S	Bone replce graft first site	031	1.33	$70.52	$14.10	$14.10
D4264	S	Bone replce graft each add	031	1.33	$70.52	$14.10	$14.10
D4266	E	Guided tiss regen resorble					
D4267	E	Guided tiss regen nonresorb					
D4270	S	Pedicle soft tissue graft pr	031	1.33	$70.52	$14.10	$14.10
D4271	S	Free soft tissue graft proc	031	1.33	$70.52	$14.10	$14.10
D4273	S	Subepithelial tissue graft	031	1.33	$70.52	$14.10	$14.10
D4274	E	Distal/proximal wedge proc					
D4320	E	Provision splnt intracoronal					
D4321	E	Provisional splint extracoro					
D4341	E	Periodontal scaling & root					
D4355	S	Full mouth debridement	031	1.33	$70.52	$14.10	$14.10
D4381	S	Localized chemo delivery	031	1.33	$70.52	$14.10	$14.10
D4910	E	Periodontal maint procedures					
D4920	E	Unscheduled dressing change					
D4999	E	Unspecified periodontal proc					
D5110	E	Dentures complete maxillary					
D5120	E	Dentures complete mandible					
D5130	E	Dentures immediat maxillary					
D5140	E	Dentures immediat mandible					
D5211	E	Dentures maxill part resin					
D5212	E	Dentures mand part resin					
D5213	E	Dentures maxill part metal					
D5214	E	Dentures mandibl part metal					
D5281	E	Removable partial denture					
D5410	E	Dentures adjust cmplt maxil					
D5411	E	Dentures adjust cmplt mand					
D5421	E	Dentures adjust part maxill					
D5422	E	Dentures adjust part mandbl					
D5510	E	Dentur repr broken compl bas					
D5520	E	Replace denture teeth complt					
D5610	E	Dentures repair resin base					
D5620	E	Rep part denture cast frame					
D5630	E	Rep partial denture clasp					
D5640	E	Replace part denture teeth					
D5650	E	Add tooth to partial denture					
D5660	E	Add clasp to partial denture					
D5710	E	Dentures rebase cmplt maxil					
D5711	E	Dentures rebase cmplt mand					
D5720	E	Dentures rebase part maxill					
D5721	E	Dentures rebase part mandbl					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
D5730	E	Denture reln cmplt maxil ch					
D5731	E	Denture reln cmplt mand chr					
D5740	E	Denture reln part maxil chr					
D5741	E	Denture reln part mand chr					
D5750	E	Denture reln cmplt max lab					
D5751	E	Denture reln cmplt mand lab					
D5760	E	Denture reln part maxil lab					
D5761	E	Denture reln part mand lab					
D5810	E	Denture interm cmplt maxill					
D5811	E	Denture interm cmplt mandbl					
D5820	E	Denture interm part maxill					
D5821	E	Denture interm part mandbl					
D5850	E	Denture tiss conditn maxill					
D5851	E	Denture tiss condtin mandbl					
D5860	E	Overdenture complete					
D5861	E	Overdenture partial					
D5862	E	Precision attachment					
D5899	E	Removable prosthodontic proc					
D5911	S	Facial moulage sectional	031	1.33	$70.52	$14.10	$14.10
D5912	S	Facial moulage complete	031	1.33	$70.52	$14.10	$14.10
D5913	E	Nasal prosthesis					
D5914	E	Auricular prosthesis					
D5915	E	Orbital prosthesis					
D5916	E	Ocular prosthesis					
D5919	E	Facial prosthesis					
D5922	E	Nasal septal prosthesis					
D5923	E	Ocular prosthesis interim					
D5924	E	Cranial prosthesis					
D5925	E	Facial augmentation implant					
D5926	E	Replacement nasal prosthesis					
D5927	E	Auricular replacement					
D5928	E	Orbital replacement					
D5929	E	Facial replacement					
D5931	E	Surgical obturator					
D5932	E	Postsurgical obturator					
D5933	E	Refitting of obturator					
D5934	E	Mandibular flange prosthesis					
D5935	E	Mandibular denture prosth					
D5936	E	Temp obturator prosthesis					
D5937	E	Trismus appliance					
D5951	E	Feeding aid					
D5952	E	Pediatric speech aid					
D5953	E	Adult speech aid					
D5954	E	Superimposed prosthesis					
D5955	E	Palatal lift prosthesis					
D5958	E	Intraoral con def inter plt					
D5959	E	Intraoral con def mod palat					
D5960	E	Modify speech aid prosthesis					
D5982	E	Surgical stent					
D5983	S	Radiation applicator	031	1.33	$70.52	$14.10	$14.10
D5984	S	Radiation shield	031	1.33	$70.52	$14.10	$14.10
D5985	S	Radiation cone locator	031	1.33	$70.52	$14.10	$14.10
D5986	E	Fluoride applicator					
D5987	S	Commissure splint	031	1.33	$70.52	$14.10	$14.10
D5988	E	Surgical splint					
D5999	E	Maxillofacial prosthesis					
D6010	E	Odontics endosteal implant					
D6020	E	Odontics abutment placement					
D6040	E	Odontics eposteal implant					
D6050	E	Odontics transosteal implnt					
D6055	E	Implant connecting bar					
D6080	E	Implant maintenance					
D6090	E	Repair implant					
D6095	E	Odontics repr abutment					
D6100	E	Removal of implant					
D6199	E	Implant procedure					
D6210	E	Prosthodont high noble metal					
D6211	E	Bridge base metal cast					
D6212	E	Bridge noble metal cast					
D6240	E	Bridge porcelain high noble					
D6241	E	Bridge porcelain base metal					
D6242	E	Bridge porcelain nobel metal					
D6250	E	Bridge resin w/high noble					
D6251	E	Bridge resin base metal					
D6252	E	Bridge resin w/noble metal					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
D6520	E	Dental retainer two surfaces					
D6530	E	Retainer metallic 3+ surface					
D6543	E	Dental retainr onlay 3 surf					
D6544	E	Dental retainr onlay 4/more					
D6545	E	Dental retainr cast metl					
D6720	E	Retain crown resin w hi nble					
D6721	E	Crown resin w/base metal					
D6722	E	Crown resin w/noble metal					
D6750	E	Crown porcelain high noble					
D6751	E	Crown porcelain base metal					
D6752	E	Crown porcelain noble metal					
D6780	E	Crown 3/4 high noble metal					
D6790	E	Crown full high noble metal					
D6791	E	Crown full base metal cast					
D6792	E	Crown full noble metal cast					
D6920	S	Dental connector bar	031	1.33	$70.52	$14.10	$14.10
D6930	E	Dental recement bridge					
D6940	E	Stress breaker					
D6950	E	Precision attachment					
D6970	E	Post & core plus retainer					
D6971	E	Cast post bridge retainer					
D6972	E	Prefab post & core plus reta					
D6973	E	Core build up for retainer					
D6975	E	Coping metal					
D6980	E	Bridge repair					
D6999	E	Fixed prosthodontic proc					
D7110	S	Oral surgery single tooth	031	1.33	$70.52	$14.10	$14.10
D7120	S	Each add tooth extraction	031	1.33	$70.52	$14.10	$14.10
D7130	S	Tooth root removal	031	1.33	$70.52	$14.10	$14.10
D7210	S	Rem imp tooth w mucoper flp	031	1.33	$70.52	$14.10	$14.10
D7220	S	Impact tooth remov soft tiss	031	1.33	$70.52	$14.10	$14.10
D7230	S	Impact tooth remov part bony	031	1.33	$70.52	$14.10	$14.10
D7240	S	Impact tooth remov comp bony	031	1.33	$70.52	$14.10	$14.10
D7241	S	Impact tooth rem bony w/comp	031	1.33	$70.52	$14.10	$14.10
D7250	S	Tooth root removal	031	1.33	$70.52	$14.10	$14.10
D7260	S	Oral antral fistula closure	031	1.33	$70.52	$14.10	$14.10
D7270	E	Tooth reimplantation					
D7272	E	Tooth transplantation					
D7280	E	Exposure impact tooth orthod					
D7281	E	Exposure tooth aid eruption					
D7285	E	Biopsy of oral tissue hard					
D7286	E	Biopsy of oral tissue soft					
D7290	E	Repositioning of teeth					
D7291	S	Transseptal fiberotomy	031	1.33	$70.52	$14.10	$14.10
D7310	E	Alveoplasty w/ extraction					
D7320	E	Alveoplasty w/o extraction					
D7340	E	Vestibuloplasty ridge extens					
D7350	E	Vestibuloplasty exten graft					
D7410	E	Rad exc lesion up to 1.25 cm					
D7420	E	Lesion > 1.25 cm					
D7430	E	Exc benign tumor to 1.25 cm					
D7431	E	Benign tumor exc > 1.25 cm					
D7440	E	Malig tumor exc to 1.25 cm					
D7441	E	Malig tumor > 1.25 cm					
D7450	E	Rem odontogen cyst to 1.25cm					
D7451	E	Rem odontogen cyst > 1.25 cm					
D7460	E	Rem nonodonto cyst to 1.25cm					
D7461	E	Rem nonodonto cyst > 1.25 cm					
D7465	E	Lesion destruction					
D7470	E	Rem exostosis maxilla/mandib					
D7480	E	Partial ostectomy					
D7490	E	Mandible resection					
D7510	E	I&d absc intraoral soft tiss					
D7520	E	I&d abscess extraoral					
D7530	E	Removal fb skin/areolar tiss					
D7540	E	Removal of fb reaction					
D7550	E	Removal of sloughed off bone					
D7560	E	Maxillary sinusotomy					
D7610	E	Maxilla open reduct simple					
D7620	E	Clsd reduct simpl maxilla fx					
D7630	E	Open red simpl mandible fx					
D7640	E	Clsd red simpl mandible fx					
D7650	E	Open red simp malar/zygom fx					
D7660	E	Clsd red simp malar/zygom fx					
D7670	E	Open red simple alveolus fx					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
D7680	E	Reduct simple facial bone fx					
D7710	E	Maxilla open reduct compound					
D7720	E	Clsd reduct compd maxilla fx					
D7730	E	Open reduct compd mandble fx					
D7740	E	Clsd reduct compd mandble fx					
D7750	E	Open red comp malar/zygma fx					
D7760	E	Clsd red comp malar/zygma fx					
D7770	E	Open reduc compd alveolus fx					
D7780	E	Reduct compnd facial bone fx					
D7810	E	Tmj open reduct-dislocation					
D7820	E	Closed tmp manipulation					
D7830	E	Tmj manipulation under anest					
D7840	E	Removal of tmj condyle					
D7850	E	Tmj meniscectomy					
D7852	E	Tmj repair of joint disc					
D7854	E	Tmj excisn of joint membrane					
D7856	E	Tmj cutting of a muscle					
D7858	E	Tmj reconstruction					
D7860	E	Tmj cutting into joint					
D7865	E	Tmj reshaping components					
D7870	E	Tmj aspiration joint fluid					
D7872	E	Tmj diagnostic arthroscopy					
D7873	E	Tmj arthroscopy lysis adhesn					
D7874	E	Tmj arthroscopy disc reposit					
D7875	E	Tmj arthroscopy synovectomy					
D7876	E	Tmj arthroscopy discectomy					
D7877	E	Tmj arthroscopy debridement					
D7880	E	Occlusal orthotic appliance					
D7899	E	Tmj unspecified therapy					
D7910	E	Dent sutur recent wnd to 5cm					
D7911	E	Dental suture wound to 5 cm					
D7912	E	Suture complicate wnd > 5 cm					
D7920	E	Dental skin graft					
D7940	S	Reshaping bone orthognathic	031	1.33	$70.52	$14.10	$14.10
D7941	E	Bone cutting ramus closed					
D7942	E	Bone cutting ramus open					
D7943	E	Cutting ramus open w/graft					
D7944	E	Bone cutting segmented					
D7945	E	Bone cutting body mandible					
D7946	E	Reconstruction maxilla total					
D7947	E	Reconstruct maxilla segment					
D7948	E	Reconstruct midface no graft					
D7949	E	Reconstruct midface w/graft					
D7950	E	Mandible graft					
D7955	E	Repair maxillofacial defects					
D7960	E	Frenulectomy/frenulotomy					
D7970	E	Excision hyperplastic tissue					
D7971	E	Excision pericoronal gingiva					
D7980	E	Sialolithotomy					
D7981	E	Excision of salivary gland					
D7982	E	Sialodochoplasty					
D7983	E	Closure of salivary fistula					
D7990	E	Emergency tracheotomy					
D7991	E	Dental coronoidectomy					
D7995	E	Synthetic graft facial bones					
D7996	E	Implant mandible for augment					
D7999	E	Oral surgery procedure					
D8010	E	Limited dental tx primary					
D8020	E	Limited dental tx transition					
D8030	E	Limited dental tx adolescent					
D8040	E	Limited dental tx adult					
D8050	E	Intercep dental tx primary					
D8060	E	Intercep dental tx transitn					
D8070	E	Compre dental tx transition					
D8080	E	Compre dental tx adolescent					
D8090	E	Compre dental tx adult					
D8210	E	Orthodontic rem appliance tx					
D8220	E	Fixed appliance therapy habt					
D8660	E	Preorthodontic tx visit					
D8670	E	Periodic orthodontc tx visit					
D8680	E	Orthodontic retention					
D8690	E	Orthodontic treatment					
D8999	E	Orthodontic procedure					
D9110	N	Tx dental pain minor proc					
D9210	E	Dent anesthesia w/o surgery					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
D9211	E	Regional block anesthesia					
D9212	E	Trigeminal block anesthesia					
D9215	E	Local anesthesia					
D9220	E	General anesthesia					
D9221	E	General anesthesia ea ad 15m					
D9230	N	Analgesia					
D9240	E	Intravenous sedation					
D9310	E	Dental consultation					
D9410	E	Dental house call					
D9420	E	Hospital call					
D9430	E	Office visit during hours					
D9440	E	Office visit after hours					
D9610	E	Dent therapeutic drug inject					
D9630	S	Other drugs/medicaments	031	1.33	$70.52	$14.10	$14.10
D9910	E	Dent appl desensitizing med					
D9920	E	Behavior management					
D9930	S	Treatment of complications	031	1.33	$70.52	$14.10	$14.10
D9940	S	Dental occlusal guard	031	1.33	$70.52	$14.10	$14.10
D9941	E	Fabrication athletic guard					
D9950	S	Occlusion analysis	031	1.33	$70.52	$14.10	$14.10
D9951	S	Limited occlusal adjustment	031	1.33	$70.52	$14.10	$14.10
D9952	S	Complete occlusal adjustment	031	1.33	$70.52	$14.10	$14.10
D9970	E	Enamel microabrasion					
D9999	E	Adjunctive procedure					
E0100	A	Cane adjust/fixed with tip					
E0105	A	Cane adjust/fixed quad/3 pro					
E0110	A	Crutch forearm pair					
E0111	A	Crutch forearm each					
E0112	A	Crutch underarm pair wood					
E0113	A	Crutch underarm each wood					
E0114	A	Crutch underarm pair no wood					
E0116	A	Crutch underarm each no wood					
E0130	A	Walker rigid adjust/fixed ht					
E0135	A	Walker folding adjust/fixed					
E0141	A	Rigid walker wheeled wo seat					
E0142	A	Walker rigid wheeled with se					
E0143	A	Walker folding wheeled w/o s					
E0145	A	Walker whled seat/crutch att					
E0146	A	Folding walker wheels w seat					
E0147	A	Walker variable wheel resist					
E0153	A	Forearm crutch platform atta					
E0154	A	Walker platform attachment					
E0155	A	Walker rigd pick-up/wheel at					
E0156	A	Walker seat attachment					
E0157	A	Walker crutch attachment					
E0158	A	Walker leg extensions					
E0159	A	Brake for wheeled walker					
E0160	A	Sitz type bath or equipment					
E0161	A	Sitz bath/equipment w/faucet					
E0162	A	Sitz bath chair					
E0163	A	Commode chair stationry fxd					
E0164	A	Commode chair mobile fixed a					
E0165	A	Commode chair stationry det					
E0166	A	Commode chair mobile detach					
E0167	A	Commode chair pail or pan					
E0175	A	Commode chair foot rest					
E0176	A	Air pressre pad/cushion nonp					
E0177	A	Water press pad/cushion nonp					
E0178	A	Gel pressre pad/cushion nonp					
E0179	A	Dry pressre pad/cushion nonp					
E0180	A	Press pad alternating w pump					
E0181	A	Press pad alternating w/ pum					
E0182	A	Pressure pad alternating pum					
E0184	A	Dry pressure mattress					
E0185	A	Gel pressure mattress pad					
E0186	A	Air pressure mattress					
E0187	A	Water pressure mattress					
E0188	E	Synthetic sheepskin pad					
E0189	E	Lambswool sheepskin pad					
E0191	A	Protector heel or elbow					
E0192	A	Pad wheelchr low press/posit					
E0193	A	Powered air flotation bed					
E0194	A	Air fluidized bed					
E0196	A	Gel pressure mattress					
E0197	A	Air pressure pad for mattres					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
E0198	A	Water pressure pad for mattr					
E0199	A	Dry pressure pad for mattres					
E0200	A	Heat lamp without stand					
E0202	A	Phototherapy light w/ photom					
E0205	A	Heat lamp with stand					
E0210	A	Electric heat pad standard					
E0215	A	Electric heat pad moist					
E0217	A	Water circ heat pad w pump					
E0218	A	Water circ cold pad w pump					
E0220	A	Hot water bottle					
E0225	A	Hydrocollator unit					
E0230	A	Ice cap or collar					
E0235	A	Paraffin bath unit portable					
E0236	A	Pump for water circulating p					
E0238	A	Heat pad non-electric moist					
E0239	A	Hydrocollator unit portable					
E0241	E	Bath tub wall rail					
E0242	E	Bath tub rail floor					
E0243	E	Toilet rail					
E0244	E	Toilet seat raised					
E0245	E	Tub stool or bench					
E0246	A	Transfer tub rail attachment					
E0249	A	Pad water circulating heat u					
E0250	A	Hosp bed fixed ht w/ mattres					
E0251	A	Hosp bed fixd ht w/o mattres					
E0255	A	Hospital bed var ht w/ mattr					
E0256	A	Hospital bed var ht w/o matt					
E0260	A	Hosp bed semi-electr w/ matt					
E0261	A	Hosp bed semi-electr w/o mat					
E0265	A	Hosp bed total electr w/ mat					
E0266	A	Hosp bed total elec w/o matt					
E0270	A	Hospital bed institutional t					
E0271	A	Mattress innerspring					
E0272	A	Mattress foam rubber					
E0273	A	Bed board					
E0274	A	Over-bed table					
E0275	A	Bed pan standard					
E0276	A	Bed pan fracture					
E0277	A	Powered pres-redu air mattrs					
E0280	A	Bed cradle					
E0290	A	Hosp bed fx ht w/o rails w/m					
E0291	A	Hosp bed fx ht w/o rail w/o					
E0292	A	Hosp bed var ht w/o rail w/o					
E0293	A	Hosp bed var ht w/o rail w/					
E0294	A	Hosp bed semi-elect w/ mattr					
E0295	A	Hosp bed semi-elect w/o matt					
E0296	A	Hosp bed total elect w/ matt					
E0297	A	Hosp bed total elect w/o mat					
E0305	A	Rails bed side half length					
E0310	A	Rails bed side full length					
E0315	A	Bed accessory brd/tbl/supprt					
E0325	A	Urinal male jug-type					
E0326	A	Urinal female jug-type					
E0350	A	Control unit bowel system					
E0352	A	Disposable pack w/bowel syst					
E0370	A	Air elevator for heel					
E0371	A	Nonpower mattress overlay					
E0372	A	Powered air mattress overlay					
E0373	A	Nonpowered pressure mattress					
E0424	A	Stationary compressed gas 02					
E0425	A	Gas system stationary compre					
E0430	A	Oxygen system gas portable					
E0431	A	Portable gaseous 02					
E0434	A	Portable liquid 02					
E0435	A	Oxygen system liquid portabl					
E0439	A	Stationary liquid 02					
E0440	A	Oxygen system liquid station					
E0441	A	Oxygen contents gas per/unit					
E0442	A	Oxygen contents liq per/unit					
E0443	A	Port 02 contents gas/unit					
E0444	A	Port 02 contents liq/unit					
E0450	A	Volume vent stationary/porta					
E0452	A	Intermit assis device w cpap					
E0453	A	Ventilator 12 hrs/less per d					
E0455	A	Oxygen tent excl croup/ped t					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
E0457	A	Chest shell					
E0459	A	Chest wrap					
E0460	A	Neg press vent portabl/statn					
E0462	A	Rocking bed w/ or w/o side r					
E0480	A	Percussor elect/pneum home m					
E0500	A	Ippb all types					
E0550	A	Humidif extens supple w ippb					
E0555	A	Humidifier for use w/ regula					
E0560	A	Humidifier supplemental w/ i					
E0565	A	Compressor air power source					
E0570	A	Nebulizer with compression					
E0575	A	Nebulizer ultrasonic					
E0580	A	Nebulizer for use w/ regulat					
E0585	A	Nebulizer w/ compressor & he					
E0600	A	Suction pump portab hom modl					
E0601	A	Cont airway pressure device					
E0605	A	Vaporizer room type					
E0606	A	Drainage board postural					
E0607	A	Blood glucose monitor home					
E0608	A	Apnea monitor					
E0609	A	Blood gluc mon w/special fea					
E0610	A	Pacemaker monitr audible/vis					
E0615	A	Pacemaker monitr digital/vis					
E0621	A	Patient lift sling or seat					
E0625	A	Patient lift bathroom or toi					
E0627	A	Seat lift incorp lift-chair					
E0628	A	Seat lift for pt furn-electr					
E0629	A	Seat lift for pt furn-non-el					
E0630	A	Patient lift hydraulic					
E0635	A	Patient lift electric					
E0650	A	Pneuma compresor non-segment					
E0651	A	Pneum compressor segmental					
E0652	A	Pneum compres w/cal pressure					
E0655	A	Pneumatic appliance half arm					
E0660	A	Pneumatic appliance full leg					
E0665	A	Pneumatic appliance full arm					
E0666	A	Pneumatic appliance half leg					
E0667	A	Seg pneumatic appl full leg					
E0668	A	Seg pneumatic appl full arm					
E0669	A	Seg pneumatic appli half leg					
E0671	A	Pressure pneum appl full leg					
E0672	A	Pressure pneum appl full arm					
E0673	A	Pressure pneum appl half leg					
E0690	A	Ultraviolet cabinet					
E0700	A	Safety equipment					
E0710	A	Restraints any type					
E0720	A	Tens two lead					
E0730	A	Tens four lead					
E0731	A	Conductive garment for tens/					
E0740	A	Incontinence treatment systm					
E0744	A	Neuromuscular stim for scoli					
E0745	A	Neuromuscular stim for shock					
E0746	A	Electromyograph biofeedback					
E0747	A	Elec osteogen stim not spine					
E0748	A	Elec osteogen stim spinal					
E0749	A	Elec osteogen stim implanted					
E0751	A	Pulse generator or receiver					
E0753	A	Neurostimul electrodes/leads					
E0755	A	Electronic salivary reflex s					
E0760	A	Osteogen ultrasound stimltor					
E0776	A	Iv pole					
E0781	A	External ambulatory infus pu					
E0782	A	Non-programble infusion pump					
E0783	A	Programmable infusion pump					
E0784	A	Ext amb infusn pump insulin					
E0791	A	Parenteral infusion pump sta					
E0840	A	Tract frame attach headboard					
E0850	A	Traction stand free standing					
E0855	A	Cervical traction equipment					
E0860	A	Tract equip cervical tract					
E0870	A	Tract frame attach footboard					
E0880	A	Trac stand free stand extrem					
E0890	A	Traction frame attach pelvic					
E0900	A	Trac stand free stand pelvic					
E0910	A	Trapeze bar attached to bed					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
E0920	A	Fracture frame attached to b					
E0930	A	Fracture frame free standing					
E0935	A	Exercise device passive moti					
E0940	A	Trapeze bar free standing					
E0941	A	Gravity assisted traction de					
E0942	A	Cervical head harness/halter					
E0943	A	Cervical pillow					
E0944	A	Pelvic belt/harness/boot					
E0945	A	Belt/harness extremity					
E0946	A	Fracture frame dual w cross					
E0947	A	Fracture frame attachmnts pe					
E0948	A	Fracture frame attachmnts ce					
E0950	A	Tray					
E0951	A	Loop heel					
E0952	A	Loop tie					
E0953	A	Pneumatic tire					
E0954	A	Wheelchair semi-pneumatic ca					
E0958	A	Whlchr att-conv 1 arm drive					
E0959	A	Amputee adapter					
E0961	A	Wheelchair brake extension					
E0962	A	Wheelchair 1 inch cushion					
E0963	A	Wheelchair 2 inch cushion					
E0964	A	Wheelchair 3 inch cushion					
E0965	A	Wheelchair 4 inch cushion					
E0966	A	Wheelchair head rest extensi					
E0967	A	Wheelchair hand rims					
E0968	A	Wheelchair commode seat					
E0969	A	Wheelchair narrowing device					
E0970	A	Wheelchair no. 2 footplates					
E0971	A	Wheelchair anti-tipping devi					
E0972	A	Transfer board or device					
E0973	A	Wheelchair adjustabl height					
E0974	A	Wheelchair grade-aid					
E0975	A	Wheelchair reinforced seat u					
E0976	A	Wheelchair reinforced back u					
E0977	A	Wheelchair wedge cushion					
E0978	A	Wheelchair belt w/airplane b					
E0979	A	Wheelchair belt with velcro					
E0980	A	Wheelchair safety vest					
E0990	A	Whellchair elevating leg res					
E0991	A	Wheelchair upholstry seat					
E0992	A	Wheelchair solid seat insert					
E0993	A	Wheelchair back upholstery					
E0994	A	Wheelchair arm rest					
E0995	A	Wheelchair calf rest					
E0996	A	Wheelchair tire solid					
E0997	A	Wheelchair caster w/ a fork					
E0998	A	Wheelchair caster w/o a fork					
E0999	A	Wheelchr pneumatic tire w/wh					
E1000	A	Wheelchair tire pneumatic ca					
E1001	A	Wheelchair wheel					
E1031	A	Rollabout chair with casters					
E1050	A	Whelchr fxd full length arms					
E1060	A	Wheelchair detachable arms					
E1065	A	Wheelchair power attachment					
E1066	A	Wheelchair battery charger					
E1069	A	Wheelchair deep cycle batter					
E1070	A	Wheelchair detachable foot r					
E1083	A	Hemi-wheelchair fixed arms					
E1084	A	Hemi-wheelchair detachable a					
E1085	A	Hemi-wheelchair fixed arms					
E1086	A	Hemi-wheelchair detachable a					
E1087	A	Wheelchair lightwt fixed arm					
E1088	A	Wheelchair lightweight det a					
E1089	A	Wheelchair lightwt fixed arm					
E1090	A	Wheelchair lightweight det a					
E1091	A	Wheelchair youth					
E1092	A	Wheelchair wide w/ leg rests					
E1093	A	Wheelchair wide w/ foot rest					
E1100	A	Whchr s-recl fxd arm leg res					
E1110	A	Wheelchair semi-recl detach					
E1130	A	Whlchr stand fxd arm ft rest					
E1140	A	Wheelchair standard detach a					
E1150	A	Wheelchair standard w/ leg r					
E1160	A	Wheelchair fixed arms					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
E1170	A	Whlchr ampu fxd arm leg rest					
E1171	A	Wheelchair amputee w/o leg r					
E1172	A	Wheelchair amputee detach ar					
E1180	A	Wheelchair amputee w/ foot r					
E1190	A	Wheelchair amputee w/ leg re					
E1195	A	Wheelchair amputee heavy dut					
E1200	A	Wheelchair amputee fixed arm					
E1210	A	Whlchr moto ful arm leg rest					
E1211	A	Wheelchair motorized w/ det					
E1212	A	Wheelchair motorized w full					
E1213	A	Wheelchair motorized w/ det					
E1220	A	Whlchr special size/constrc					
E1221	A	Wheelchair spec size w foot					
E1222	A	Wheelchair spec size w/ leg					
E1223	A	Wheelchair spec size w foot					
E1224	A	Wheelchair spec size w/ leg					
E1225	A	Wheelchair spec sz semi-recl					
E1226	A	Wheelchair spec sz full-recl					
E1227	A	Wheelchair spec sz spec ht a					
E1228	A	Wheelchair spec sz spec ht b					
E1230	A	Power operated vehicle					
E1240	A	Whchr litwt det arm leg rest					
E1250	A	Wheelchair lightwt fixed arm					
E1260	A	Wheelchair lightwt foot rest					
E1270	A	Wheelchair lightweight leg r					
E1280	A	Whchr h-duty det arm leg res					
E1285	A	Wheelchair heavy duty fixed					
E1290	A	Wheelchair hvy duty detach a					
E1295	A	Wheelchair heavy duty fixed					
E1296	A	Wheelchair special seat heig					
E1297	A	Wheelchair special seat dept					
E1298	A	Wheelchair spec seat depth/w					
E1300	A	Whirlpool portable					
E1310	A	Whirlpool non-portable					
E1340	A	Repair for DME, per 15 min					
E1353	A	Oxygen supplies regulator					
E1355	A	Oxygen supplies stand/rack					
E1372	A	Oxy suppl heater for nebuliz					
E1375	A	Oxygen suppl nebulizer porta					
E1377	A	Oxygen concentrator to 244 c					
E1378	A	Oxygen concentrator to 488 c					
E1379	A	Oxygen concentrator to 732 c					
E1380	A	Oxygen concentrator to 976 c					
E1381	A	Oxygen concentrat to 1220 cu					
E1382	A	Oxygen concentrat to 1464 cu					
E1383	A	Oxygen concentrat to 1708 cu					
E1384	A	Oxygen concentrat to 1952 cu					
E1385	A	Oxygen concentrator > 1952 c					
E1399	A	Durable medical equipment mi					
E1400	A	Oxygen concentrator < 2 lite					
E1401	A	Oxygen concentrator 2–3 lite					
E1402	A	Oxygen concentrator 3–4 lite					
E1403	A	Oxygen concentrator 4–5 lite					
E1404	A	Oxygen concentrator > 5 lite					
E1405	A	O2/water vapor enrich w/heat					
E1406	A	O2/water vapor enrich w/o he					
E1510	A	Kidney dialysate delivry sys					
E1520	A	Heparin infusion pump for di					
E1530	A	Air bubble detector for dial					
E1540	A	Pressure alarm for dialysis					
E1550	A	Bath conductivity meter					
E1560	A	Blood leak detector for dial					
E1570	A	Adjustable chair for esrd pt					
E1575	A	Transducer protector/fluid b					
E1580	A	Unipuncture control system					
E1590	A	Hemodialysis machine					
E1592	A	Auto interm peritoneal dialy					
E1594	A	Cycler dialysis machine					
E1600	A	Deliv/install equip for dial					
E1610	A	Reverse osmosis water purifi					
E1615	A	Deionizer water purification					
E1620	A	Blood pump for dialysis					
E1625	A	Water softening system					
E1630	A	Reciprocating peritoneal dia					
E1632	A	Wearable artificial kidney					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
E1635	A	Compact travel hemodialyzer					
E1636	A	Sorbent cartridges for dialy					
E1640	A	Replacement components for d					
E1699	A	Dialysis equipment unspecifi					
E1700	A	Jaw motion rehab system					
E1701	A	Repl cushions for jaw motion					
E1702	A	Repl measr scales jaw motion					
E1800	A	Adjust elbow ext/flex device					
E1805	A	Adjust wrist ext/flex device					
E1810	A	Adjust knee ext/flex device					
E1815	A	Adjust ankle ext/flex device					
E1820	A	Soft interface material					
E1825	A	Adjust finger ext/flex devc					
E1830	A	Adjust toe ext/flex device					
G0001	N	Drawing blood for specimen					
G0002	N	Temporary urinary catheter					
G0004	X	ECG transm phys review & int	956	1.11	$58.77	$55.82	$11.75
G0005	X	ECG 24 hour recording	956	1.11	$58.77	$55.82	$11.75
G0006	X	ECG transmission & analysis	956	1.11	$58.77	$55.82	$11.75
G0007	N	ECG phy review & interpret					
G0008	X	Admin influenza virus vac	901	0.07	$3.92	$2.49	$0.78
G0009	X	Admin pneumococcal vaccine	901	0.07	$3.92	$2.49	$0.78
G0010	X	Admin hepatitis b vaccine	902	1.78	$94.03	$41.58	$18.81
G0015	X	Post symptom ECG tracing	956	1.11	$58.77	$55.82	$11.75
G0016	N	Post symptom ECG md review					
G0025	X	Collagen skin test kit	881	0.20	$10.77	$6.78	$2.15
G0026	A	Fecal leukocyte examination					
G0027	A	Semen analysis					
G0030	S	PET imaging prev PET single	760	17.91	$947.13	$419.46	$189.43
G0031	S	PET imaging prev PET multple	760	17.91	$947.13	$419.46	$189.43
G0032	S	PET follow SPECT 78464 singl	760	17.91	$947.13	$419.46	$189.43
G0033	S	PET follow SPECT 78464 mult	760	17.91	$947.13	$419.46	$189.43
G0034	S	PET follow SPECT 76865 singl	760	17.91	$947.13	$419.46	$189.43
G0035	S	PET follow SPECT 78465 mult	760	17.91	$947.13	$419.46	$189.43
G0036	S	PET follow cornry angio sing	760	17.91	$947.13	$419.46	$189.43
G0037	S	PET follow cornry angio mult	760	17.91	$947.13	$419.46	$189.43
G0038	S	PET follow myocard perf sing	760	17.91	$947.13	$419.46	$189.43
G0039	S	PET follow myocard perf mult	760	17.91	$947.13	$419.46	$189.43
G0040	S	PET follow stress echo singl	760	17.91	$947.13	$419.46	$189.43
G0041	S	PET follow stress echo mult	760	17.91	$947.13	$419.46	$189.43
G0042	S	PET follow ventriculogm sing	760	17.91	$947.13	$419.46	$189.43
G0043	S	PET follow ventriculogm mult	760	17.91	$947.13	$419.46	$189.43
G0044	S	PET following rest ECG singl	760	17.91	$947.13	$419.46	$189.43
G0045	S	PET following rest ECG mult	760	17.91	$947.13	$419.46	$189.43
G0046	S	PET follow stress ECG singl	760	17.91	$947.13	$419.46	$189.43
G0047	S	PET follow stress ECG mult	760	17.91	$947.13	$419.46	$189.43
G0050	S	Residual urine by ultrasound	747	1.65	$87.17	$54.69	$17.43
G0101	V	CA screen;pelvic/breast exam	913				
G0104	T	CA screen;flexi sigmoidscope	446	2.59	$137.12	$65.09	$27.42
G0105	T	Colorectal scrn; hi risk ind	426	6.85	$362.40	$187.81	$72.48
G0106	S	Colon CA screen;barium enema	736	1.85	$97.95	$54.24	$19.59
G0107	A	CA screen; fecal blood test					
G0110	A	Nett pulm-rehab educ; ind					
G0111	A	Nett pulm-rehab educ; group					
G0112	A	Nett;nutrition guid, initial					
G0113	A	Nett;nutrition guid,subseqnt					
G0114	A	Nett; psychosocial consult					
G0115	A	Nett; psychological testing					
G0116	A	Nett; psychosocial counsel					
G0120	S	Colon ca scrn; barium enema	736	1.85	$97.95	$54.24	$19.59
G0121	E	Colon ca scrn; barium enema					
G0122	E	Colon ca scrn; barium enema					
J0120	N	Tetracyclin injection					
J0150	N	Injection adenosine 6 MG					
J0170	N	Adrenalin epinephrin inject					
J0190	N	Inj biperiden lactate/5 mg					
J0205	N	Alglucerase injection					
J0207	N	Amifostine					
J0210	N	Methyldopate hcl injection					
J0256	N	Alpha 1-proteinase 500 MG					
J0270	E	Alprostadil for injection					
J0280	N	Aminophyllin 250 MG inj					
J0290	N	Ampicillin 500 MG inj					
J0295	N	Ampicillin sodium per 1.5 gm					
J0300	N	Amobarbital 125 MG inj					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
J0330	N	Succinycholine chloride inj					
J0340	N	Nandrolon phenpropionate inj					
J0350	N	Injection anistreplase 30 u					
J0360	N	Hydralazine hcl injection					
J0380	N	Inj metaraminol bitartrate					
J0390	N	Chloroquine injection					
J0400	N	Inj trimethaphan camsylate					
J0460	N	Atropine sulfate injection					
J0470	N	Dimecaprol injection					
J0475	N	Baclofen 10 MG injection					
J0500	N	Dicyclomine injection					
J0510	N	Benzquinamide injection					
J0515	N	Inj benztropine mesylate					
J0520	N	Bethanechol chloride inject					
J0530	N	Penicillin g benzathine inj					
J0540	N	Penicillin g benzathine inj					
J0550	N	Penicillin g benzathine inj					
J0560	N	Penicillin g benzathine inj					
J0570	N	Penicillin g benzathine inj					
J0580	N	Penicillin g benzathine inj					
J0585	N	Botulinum toxin a per unit					
J0590	N	Ethylnorepinephrine hcl inj					
J0600	N	Edetate calcium disodium inj					
J0610	N	Calcium gluconate injection					
J0620	N	Calcium glycer & lact/10 ML					
J0630	N	Calcitonin salmon injection					
J0635	N	Calcitriol injection					
J0640	X	Leucovorin calcium injection	064	4.17	$220.38	$140.12	$44.08
J0670	N	Inj mepivacaine HCL/10 ml					
J0690	N	Cefazolin sodium injection					
J0694	N	Cefoxitin sodium injection					
J0695	N	Cefonocid sodium injection					
J0696	N	Ceftriaxone sodium injection					
J0697	N	Sterile cefuroxime injection					
J0698	N	Cefotaxime sodium injection					
J0702	N	Betamethasone acet&sod phosp					
J0704	N	Betamethasone sod phosp/4 MG					
J0710	N	Cephapirin sodium injection					
J0713	N	Inj ceftazidime per 500 mg					
J0715	N	Ceftizoxime sodium / 500 MG					
J0720	N	Chloramphenicol sodium injec					
J0725	N	Chorionic gonadotropin/1000u					
J0730	N	Chlorpheniramin maleate inj					
J0735	N	Clonidine hydrochloride					
J0740	N	Cidofovir injection					
J0743	N	Cilastatin sodium injection					
J0745	N	Inj codeine phosphate /30 MG					
J0760	N	Colchicine injection					
J0770	N	Colistimethate sodium inj					
J0780	N	Prochlorperazine injection					
J0800	N	Corticotropin injection					
J0810	N	Cortisone injection					
J0835	N	Inj cosyntropin per 0.25 MG					
J0850	N	Cytomegalovirus imm IV /vial					
J0895	N	Deferoxamine mesylate inj					
J0900	N	Testosterone enanthate inj					
J0945	N	Brompheniramine maleate inj					
J0970	N	Estradiol valerate injection					
J1000	N	Depo-estradiol cypionate inj					
J1020	N	Methylprednisolone 20 MG inj					
J1030	N	Methylprednisolone 40 MG inj					
J1040	N	Methylprednisolone 80 MG inj					
J1050	N	Medroxyprogesterone inj					
J1055	E	Medrxyprogester acetate inj					
J1060	N	Testosterone cypionate 1 ML					
J1070	N	Testosterone cypionat 100 MG					
J1080	N	Testosterone cypionat 200 MG					
J1090	N	Testosterone cypionate 50 MG					
J1095	N	Inj dexamethasone acetate					
J1100	N	Dexamethosone sodium phos					
J1110	N	Inj dihydroergotamine mesylt					
J1120	N	Acetazolamid sodium injectio					
J1160	N	Digoxin injection					
J1165	N	Phenytoin sodium injection					
J1170	N	Hydromorphone injection					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
J1180	N	Dyphylline injection					
J1190	N	Dexrazoxane HCl injection					
J1200	N	Diphenhydramine hcl injectio					
J1205	N	Chlorothiazide sodium inj					
J1212	N	Dimethyl sulfoxide 50% 50 ML					
J1230	N	Methadone injection					
J1240	N	Dimenhydrinate injection					
J1245	N	Dipyridamole injection					
J1250	N	Inj dobutamine HCL/250 mg					
J1320	N	Amitriptyline injection					
J1325	N	Epoprostenol injection					
J1330	N	Ergonovine maleate injection					
J1362	N	Erythromycin glucep / 250 MG					
J1364	N	Erythro lactobionate /500 MG					
J1380	N	Estradiol valerate 10 MG inj					
J1390	N	Estradiol valerate 20 MG inj					
J1410	N	Inj estrogen conjugate 25 MG					
J1435	N	Injection estrone per 1 MG					
J1436	N	Etidronate disodium inj					
J1440	N	Filgrastim 300 mcg injeciton					
J1441	N	Filgrastim 480 mcg injection					
J1455	N	Foscarnet sodium injection					
J1460	N	Gamma globulin 1 CC inj					
J1470	N	Gamma globulin 2 CC inj					
J1480	N	Gamma globulin 3 CC inj					
J1490	N	Gamma globulin 4 CC inj					
J1500	N	Gamma globulin 5 CC inj					
J1510	N	Gamma globulin 6 CC inj					
J1520	N	Gamma globulin 7 CC inj					
J1530	N	Gamma globulin 8 CC inj					
J1540	N	Gamma globulin 9 CC inj					
J1550	N	Gamma globulin 10 CC inj					
J1560	N	Gamma globulin > 10 CC inj					
J1561	N	Immune globulin 500 mg					
J1562	N	Immune globulin 5 gms					
J1565	N	RSV-ivig					
J1570	N	Ganciclovir sodium injection					
J1580	N	Garamycin gentamicin inj					
J1600	N	Gold sodium thiomaleate inj					
J1610	N	Glucagon hydrochloride/1 MG					
J1620	N	Gonadorelin hydroch/ 100 mcg					
J1626	N	Granisetron HCl injection					
J1630	N	Haloperidol injection					
J1631	N	Haloperidol decanoate inj					
J1642	N	Inj heparin sodium per 10 u					
J1644	N	Inj heparin sodium per 1000u					
J1645	N	Dalteparin sodium					
J1650	N	Inj enoxaparin sodium 30 mg					
J1670	N	Tetanus immune globulin inj					
J1690	N	Prednisolone tebutate inj					
J1700	N	Hydrocortisone acetate inj					
J1710	N	Hydrocortisone sodium ph inj					
J1720	N	Hydrocortisone sodium succ i					
J1730	N	Diazoxide injection					
J1739	N	Hydroxyprogesterone cap 125					
J1741	N	Hydroxyprogesterone cap 250					
J1742	N	Ibutilide fumarate injection					
J1760	N	Iron dextran 2 CC inj					
J1770	N	Iron dextran 5 CC inj					
J1780	N	Iron dextran 10 CC inj					
J1785	N	Injection imiglucerase /unit					
J1790	N	Droperidol injection					
J1800	N	Propranolol injection					
J1810	N	Droperidol/fentanyl inj					
J1820	N	Insulin injection					
J1825	N	Interferon beta-1a					
J1830	N	Interferon beta-1b / .25 MG					
J1840	N	Kanamycin sulfate 500 MG inj					
J1850	N	Kanamycin sulfate 75 MG inj					
J1885	N	Ketorolac tromethamine inj					
J1890	N	Cephalothin sodium injection					
J1910	N	Kutapressin injection					
J1930	N	Propiomazine injection					
J1940	N	Furosemide injection					
J1950	X	Leuprolide acetate /3.75 MG	064	4.17	$220.38	$140.12	$44.08

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
J1955	N	Inj levocarnitine per 1 gm					
J1960	N	Levorphanol tartrate inj					
J1970	N	Methotrimeprazine injection					
J1980	N	Hyoscyamine sulfate inj					
J1990	N	Chlordiazepoxide injection					
J2000	N	Lidocaine injection					
J2010	N	Lincomycin injection					
J2060	N	Lorazepam injection					
J2150	N	Mannitol injection					
J2175	N	Meperidine hydrochl /100 MG					
J2180	N	Meperidine/promethazine inj					
J2210	N	Methylergonovin maleate inj					
J2240	N	Metocurine iodide injection					
J2250	N	Inj midazolam hydrochloride					
J2260	N	Inj milrinone lactate / 5 ML					
J2270	N	Morphine sulfate injection					
J2275	N	Morphine sulfate injection					
J2300	N	Inj nalbuphine hydrochloride					
J2310	N	Inj naloxone hydrochloride					
J2320	N	Nandrolone decanoate 50 MG					
J2321	N	Nandrolone decanoate 100 MG					
J2322	N	Nandrolone decanoate 200 MG					
J2330	N	Thiothixene injection					
J2350	N	Niacinamide/niacin injection					
J2360	N	Orphenadrine injection					
J2370	N	Phenylephrine hcl injection					
J2400	N	Chloroprocaine hcl injection					
J2405	N	Ondansetron hcl injection					
J2410	N	Oxymorphone hcl injection					
J2430	N	Pamidronate disodium /30 MG					
J2440	N	Papaverin hcl injection					
J2460	N	Oxytetracycline injection					
J2480	N	Hydrochlorides of opium inj					
J2510	N	Penicillin g procaine inj					
J2512	N	Inj pentagastrin per 2 ML					
J2515	N	Pentobarbital sodium inj					
J2540	N	Penicillin g potassium inj					
J2545	A	Pentamidine isethionte/300mg					
J2550	N	Promethazine hcl injection					
J2560	N	Phenobarbital sodium inj					
J2590	N	Oxytocin injection					
J2597	N	Inj desmopressin acetate					
J2640	N	Prednisolone sodium ph inj					
J2650	N	Prednisolone acetate inj					
J2670	N	Totazoline hcl injection					
J2675	N	Inj progesterone per 50 MG					
J2680	N	Fluphenazine decanoate 25 MG					
J2690	N	Procainamide hcl injection					
J2700	N	Oxacillin sodium injeciton					
J2710	N	Neostigmine methylslfte inj					
J2720	N	Inj protamine sulfate/10 MG					
J2725	N	Inj protirelin per 250 mcg					
J2730	N	Pralidoxime chloride inj					
J2760	N	Phentolaine mesylate inj					
J2765	N	Metoclopramide hcl injection					
J2790	N	Rho d immune globulin inj					
J2800	N	Methocarbamol injection					
J2810	N	Inj theophylline per 40 MG					
J2820	N	Sargramostim injection					
J2860	N	Secobarbital sodium inj					
J2910	N	Aurothioglucose injeciton					
J2912	N	Sodium chloride injection					
J2920	N	Methylprednisolone injection					
J2930	N	Methylprednisolone injection					
J2950	N	Promazine hcl injeciton					
J2970	N	Methicillin sodium injection					
J2995	N	Inj streptokinase /250000 IU					
J2996	N	Alteplase recombinant inj					
J3000	N	Streptomycin injection					
J3010	N	Fentanyl citrate injeciton					
J3030	N	Sumatriptan succinate / 6 MG					
J3070	N	Pentazocine hcl injeciton					
J3080	N	Chlorprothixene injection					
J3105	N	Terbutaline sulfate inj					
J3120	N	Testosterone enanthate inj					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
J3130	N	Testosterone enanthate inj					
J3140	N	Testosterone suspension inj					
J3150	N	Testosteron propionate inj					
J3230	N	Chlorpromazine hcl injection					
J3240	N	Thyrotropin injection					
J3250	N	Trimethobenzamide hcl inj					
J3260	N	Tobramycin sulfate injection					
J3265	N	Injection torsemide 10 mg/ml					
J3270	N	Imipramine hcl injection					
J3280	N	Thiethylperazine maleate inj					
J3301	N	Triamcinolone acetonide inj					
J3302	N	Triamcinolone diacetate inj					
J3303	N	Triamcinolone hexacetonl inj					
J3305	N	Inj trimetrexate glucoronate					
J3310	N	Perphenazine injeciton					
J3320	N	Spectinomycn di–hcl inj					
J3350	N	Urea injection					
J3360	N	Diazepam injection					
J3364	N	Urokinase 5000 IU injection					
J3365	N	Urokinase 250,000 IU inj					
J3370	E	Vancomycin hcl injeciton					
J3390	N	Methoxamine injection					
J3400	N	Triflupromazine hcl inj					
J3410	N	Hydroxyzine hcl injeciton					
J3420	N	Vitamin b12 injection					
J3430	N	Vitamin k phytonadione inj					
J3450	N	Mephentermine sulfate inj					
J3470	N	Hyaluronidase injection					
J3475	N	Inj magnesium sulfate					
J3480	N	Inj potassium chloride					
J3490	N	Drugs unclassified injection					
J3520	E	Edetate disodium per 150 mg					
J3530	N	Nasal vaccine inhalation					
J3535	E	Metered dose inhaler drug					
J3570	E	Laetrile amygdalin vit B17					
J7030	A	Normal saline solution infus					
J7040	A	Normal saline solution infus					
J7042	A	5% dextrose/normal saline					
J7050	A	Normal saline solution infus					
J7051	A	Sterile saline/water					
J7060	A	5% dextrose/water					
J7070	A	D5w infusion					
J7100	A	Dextran 40 infusion					
J7110	A	Dextran 75 infusion					
J7120	A	Ringers lactate infusion					
J7130	A	Hypertonic saline solution					
J7190	N	Factor viii					
J7191	N	Factor VIII (porcine)					
J7192	N	Factor viii recombinant					
J7194	N	Factor ix complex					
J7196	N	Othr hemophilia clot factors					
J7197	N	Antithrombin iii injection					
J7300	E	Intraut copper contraceptive					
J7310	N	Ganciclovir long act implant					
J7500	N	Azathiop po tab 50mg 100s ea					
J7501	N	Azathioprine parenteral					
J7503	N	Cyclosporine parenteral					
J7504	N	Lymphocyte immune globulin					
J7505	N	Monoclonal antibodies					
J7506	N	Prednisone oral					
J7507	N	Tacrolimus oral per 1 MG					
J7508	N	Tacrolimus oral per 5 MG					
J7509	N	Methylprednisolone oral					
J7510	N	Prednisolone oral per 5 mg					
J7599	N	Immunosuppressive drug noc					
J7610	A	Acetylcysteine 10% injection					
J7615	A	Acetylcysteine 20% injection					
J7620	A	Albuterol sulfate .083%/ml					
J7625	A	Albuterol sulfate .5% inj					
J7627	A	Bitolterolmesylate inhal sol					
J7630	A	Cromolyn sodium injeciton					
J7640	A	Epinephrine injection					
J7645	A	Ipratropium bromide .02%/ml					
J7650	A	Isoetharine hcl .1% inj					
J7651	A	Isoetharine hcl .125% inj					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
J7652	A	Isoetharine hcl .167% inj	.....	.....	.....	.....	.....
J7653	A	Isoetharine hcl .2%/ inj	.....	.....	.....	.....	.....
J7654	A	Isoetharine hcl .25% inj	.....	.....	.....	.....	.....
J7655	A	Isoetharine hcl 1% inj	.....	.....	.....	.....	.....
J7660	A	Isoproterenol hcl .5% inj	.....	.....	.....	.....	.....
J7665	A	Isoproterenol hcl 1% inj	.....	.....	.....	.....	.....
J7670	A	Metaproterenol sulfate .4%	.....	.....	.....	.....	.....
J7672	A	Metaproterenol sulfate .6%	.....	.....	.....	.....	.....
J7675	A	Metaproterenol sulfate 5%	.....	.....	.....	.....	.....
J7699	A	Inhalation solution for DME	.....	.....	.....	.....	.....
J7799	A	Non-inhalation drug for DME	.....	.....	.....	.....	.....
J8499	E	Oral prescrip drug non chemo	.....	.....	.....	.....	.....
J8530	N	Cyclophosphamide oral 25 MG	.....	.....	.....	.....	.....
J8560	N	Etoposide oral 50 MG	.....	.....	.....	.....	.....
J8600	N	Melphalan oral 2 MG	.....	.....	.....	.....	.....
J8610	X	Methotrexate oral 2.5 MG	061	1.04	$54.85	$36.61	$10.97
J8999	X	Oral prescription drug chemo	061	1.04	$54.85	$36.61	$10.97
J9000	X	Doxorubic hcl 10 MG vl chemo	062	1.69	$89.13	$36.61	$17.83
J9015	X	Aldesleukin/single use vial	061	1.04	$54.85	$36.61	$10.97
J9020	X	Asparaginase injection	062	1.69	$89.13	$36.61	$17.83
J9031	X	Bcg live intravesical vac	063	2.89	$152.79	$110.97	$30.56
J9040	X	Bleomycin sulfate injection	063	2.89	$152.79	$110.97	$30.56
J9045	X	Carboplatin injection	063	2.89	$152.79	$110.97	$30.56
J9050	X	Carmus bischl nitro inj	063	2.89	$152.79	$110.97	$30.56
J9060	X	Cisplatin 10 MG injeciton	062	1.69	$89.13	$36.61	$17.83
J9062	X	Cisplatin 50 MG injeciton	063	2.89	$152.79	$110.97	$30.56
J9065	X	Inj cladribine per 1 MG	062	1.69	$89.13	$36.61	$17.83
J9070	X	Cyclophosphamide 100 MG inj	061	1.04	$54.85	$36.61	$10.97
J9080	X	Cyclophosphamide 200 MG inj	061	1.04	$54.85	$36.61	$10.97
J9090	X	Cyclophosphamide 500 MG inj	061	1.04	$54.85	$36.61	$10.97
J9091	X	Cyclophosphamide 1.0 grm inj	062	1.69	$89.13	$36.61	$17.83
J9092	X	Cyclophosphamide 2.0 grm inj	062	1.69	$89.13	$36.61	$17.83
J9093	X	Cyclophosphamide lyophilized	061	1.04	$54.85	$36.61	$10.97
J9094	X	Cyclophosphamide lyophilized	061	1.04	$54.85	$36.61	$10.97
J9095	X	Cyclophosphamide lyophilized	061	1.04	$54.85	$36.61	$10.97
J9096	X	Cyclophosphamide lyophilized	062	1.69	$89.13	$36.61	$17.83
J9097	X	Cyclophosphamide lyophilized	062	1.69	$89.13	$36.61	$17.83
J9100	X	Cytarabine hcl 100 MG inj	061	1.04	$54.85	$36.61	$10.97
J9110	X	Cytarabine hcl 500 MG inj	061	1.04	$54.85	$36.61	$10.97
J9120	X	Dactinomycin actinomycin d	061	1.04	$54.85	$36.61	$10.97
J9130	X	Dacarbazine 10 MG inj	061	1.04	$54.85	$36.61	$10.97
J9140	X	Dacarbazine 200 MG inj	061	1.04	$54.85	$36.61	$10.97
J9150	X	Daunorubicin	062	1.69	$89.13	$36.61	$17.83
J9165	X	Diethylstilbestrol injection	061	1.04	$54.85	$36.61	$10.97
J9170	X	Docetaxel	061	1.04	$54.85	$36.61	$10.97
J9181	X	Etoposide 10 MG inj	061	1.04	$54.85	$36.61	$10.97
J9182	X	Etoposide 100 MG inj	063	2.89	$152.79	$110.97	$30.56
J9185	X	Fludarabine phosphate inj	063	2.89	$152.79	$110.97	$30.56
J9190	X	Fluorouracil injection	061	1.04	$54.85	$36.61	$10.97
J9200	X	Floxuridine injection	063	2.89	$152.79	$110.97	$30.56
J9201	X	Gemcitabine HCl	061	1.04	$54.85	$36.61	$10.97
J9202	X	Goserelin acetate implant	063	2.89	$152.79	$110.97	$30.56
J9206	X	Irinotecan injection	061	1.04	$54.85	$36.61	$10.97
J9208	X	Ifosfomide injection	063	2.89	$152.79	$110.97	$30.56
J9209	X	Mesna injection	063	2.89	$152.79	$110.97	$30.56
J9211	X	Idarubicin hcl injeciton	062	1.69	$89.13	$36.61	$17.83
J9213	X	Interferon alfa-2a inj	062	1.69	$89.13	$36.61	$17.83
J9214	X	Interferon alfa-2b inj	061	1.04	$54.85	$36.61	$10.97
J9215	X	Interferon alfa-n3 inj	061	1.04	$54.85	$36.61	$10.97
J9216	X	Interferon gamma 1–b inj	063	2.89	$152.79	$110.97	$30.56
J9217	X	Leuprolide acetate suspnsion	064	4.17	$220.38	$140.12	$44.08
J9218	X	Leuprolide acetate injeciton	061	1.04	$54.85	$36.61	$10.97
J9230	X	Mechlorethamine hcl inj	061	1.04	$54.85	$36.61	$10.97
J9245	X	Inj melphalan hydrochl 50 MG	064	4.17	$220.38	$140.12	$44.08
J9250	X	Methotrexate sodium inj	061	1.04	$54.85	$36.61	$10.97
J9260	X	Methotrexate sodium inj	061	1.04	$54.85	$36.61	$10.97
J9265	X	Paclitaxel injection	062	1.69	$89.13	$36.61	$17.83
J9266	X	Pegaspargase/singl dose vial	061	1.04	$54.85	$36.61	$10.97
J9268	X	Pentostatin injection	062	1.69	$89.13	$36.61	$17.83
J9270	X	Plicamycin (mithramycin) inj	063	2.89	$152.79	$110.97	$30.56
J9280	X	Mitomycin 5 MG inj	063	2.89	$152.79	$110.97	$30.56
J9290	X	Mitomycin 20 MG inj	064	4.17	$220.38	$140.12	$44.08
J9291	X	Mitomycin 40 MG inj	064	4.17	$220.38	$140.12	$44.08
J9293	X	Mitoxantrone hydrochl / 5 MG	064	4.17	$220.38	$140.12	$44.08
J9320	X	Streptozocin injection	063	2.89	$152.79	$110.97	$30.56

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
J9340	X	Thiotepa injection	063	2.89	$152.79	$110.97	$30.56
J9350	X	Topotecan	061	1.04	$54.85	$36.61	$10.97
J9360	X	Vinblastine sulfate inj	061	1.04	$54.85	$36.61	$10.97
J9370	X	Vincristine sulfate 1 MG inj	062	1.69	$89.13	$36.61	$17.83
J9375	X	Vincristine sulfate 2 MG inj	063	2.89	$152.79	$110.97	$30.56
J9380	X	Vincristine sulfate 5 MG inj	063	2.89	$152.79	$110.97	$30.56
J9390	X	Vinorelbine tartrate/10 mg	061	1.04	$54.85	$36.61	$10.97
J9600	X	Porfimer sodium	061	1.04	$54.85	$36.61	$10.97
J9999	X	Chemotherapy drug	061	1.04	$54.85	$36.61	$10.97
K0001	A	Standard wheelchair					
K0002	A	Stnd hemi (low seat) whlchr					
K0003	A	Lightweight wheelchair					
K0004	A	High strength ltwt whlchr					
K0005	A	Ultralightweight wheelchair					
K0006	A	Heavy duty wheelchair					
K0007	A	Extra heavy duty wheelchair					
K0008	A	Cstm manual wheelchair/base					
K0009	A	Other manual wheelchair/base					
K0010	A	Stnd wt frame power whlchr					
K0011	A	Stnd wt pwr whlchr w control					
K0012	A	Ltwt portbl power whlchr					
K0013	A	Custom power whlchr base					
K0014	A	Other power whlchr base					
K0015	A	Detach non-adjus hght armrst					
K0016	A	Detach adjust armrst cmplete					
K0017	A	Detach adjust armrest base					
K0018	A	Detach adjust armrst upper					
K0019	A	Arm pad each					
K0020	A	Fixed adjust armrest pair					
K0021	A	Anti-tipping device each					
K0022	A	Reinforced back upholstery					
K0023	A	Planr back insrt foam w/strp					
K0024	A	Plnr back insrt foam w/hrdwr					
K0025	A	Hook-on headrest extension					
K0026	A	Back upholst lgtwt whlchr					
K0027	A	Back upholst other whlchr					
K0028	A	Fully reclining back					
K0029	A	Reinforced seat upholstery					
K0030	A	Solid plnr seat sngl dnsfoam					
K0031	A	Safety belt/pelvic strap					
K0032	A	Seat uphols lgtwt whlchr					
K0033	A	Seat upholstery other whlchr					
K0034	A	Heel loop each					
K0035	A	Heel loop with ankle strap					
K0036	A	Toe loop each					
K0037	A	High mount flip-up footrest					
K0038	A	Leg strap each					
K0039	A	Leg strap h style each					
K0040	A	Adjustable angle footplate					
K0041	A	Large size footplate each					
K0042	A	Standard size footplate each					
K0043	A	Ftrst lower extension tube					
K0044	A	Ftrst upper hanger bracket					
K0045	A	Footrest complete assembly					
K0046	A	Elevat legrst low extension					
K0047	A	Elevat legrst up hangr brack					
K0048	A	Elevate legrest complete					
K0049	A	Calf pad each					
K0050	A	Ratchet assembly					
K0051	A	Cam relese assem ftrst/lgrst					
K0052	A	Swingaway detach footrest					
K0053	A	Elevate footrest articulate					
K0054	A	Seat wdth 10–12/15/17/20 wc					
K0055	A	Seat dpth 15/17/18 ltwt wc					
K0056	A	Seat ht <17 or <=21 ltwt wc					
K0057	A	Seat wdth 19/20 hvy dty wc					
K0058	A	Seat dpth 17/18 power wc					
K0059	A	Plastic coated handrim each					
K0060	A	Steel handrim each					
K0061	A	Aluminum handrim each					
K0062	A	Handrim 8–10 vert/obliq proj					
K0063	A	Hndrm 12–16 vert/obliq proj					
K0064	A	Zero pressure tube flat free					
K0065	A	Spoke protectors					
K0066	A	Solid tire any size each					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
K0067	A	Pneumatic tire any size each					
K0068	A	Pneumatic tire tube each					
K0069	A	Rear whl complete solid tire					
K0070	A	Rear whl compl pneum tire					
K0071	A	Front castr compl pneum tire					
K0072	A	Frnt cstr cmpl sem-pneum tir					
K0073	A	Caster pin lock each					
K0074	A	Pneumatic caster tire each					
K0075	A	Semi-pneumatic caster tire					
K0076	A	Solid caster tire each					
K0077	A	Front caster assem complete					
K0078	A	Pneumatic caster tire tube					
K0079	A	Wheel lock extension pair					
K0080	A	Anti-rollback device pair					
K0081	A	Wheel lock assembly complete					
K0082	A	22 nf deep cycl acid battery					
K0083	A	22 nf gel cell battery each					
K0084	A	Grp 24 deep cycl acid battry					
K0085	A	Group 24 gel cell battery					
K0086	A	U–1 lead acid battery each					
K0087	A	U–1 gel cell battery each					
K0088	A	Battry chrgr acid/gel cell					
K0089	A	Battery charger dual mode					
K0090	A	Rear tire power wheelchair					
K0091	A	Rear tire tube power whlchr					
K0092	A	Rear assem cmplt powr whlchr					
K0093	A	Rear zero pressure tire tube					
K0094	A	Wheel tire for power base					
K0095	A	Wheel tire tube each base					
K0096	A	Wheel assem powr base complt					
K0097	A	Wheel zero presure tire tube					
K0098	A	Drive belt power wheelchair					
K0099	A	Front caster power whelchair					
K0100	A	Amputee adapter pair					
K0101	A	One-arm drive attachment					
K0102	A	Crutch and cane holder					
K0103	A	Transfer board < 25″					
K0104	A	Cylinder tank carrier					
K0105	A	Iv hanger					
K0106	A	Arm trough each					
K0107	A	Wheelchair tray					
K0108	A	Other accessories					
K0109	A	Customize whlchr base frame					
K0112	A	Trunk vest supprt innr frame					
K0113	A	Trunk vest suprt w/o inr frm					
K0114	A	Whlchr back suprt inr frame					
K0115	A	Back module orthotic system					
K0116	A	Back & seat modul orthot sys					
K0119	N	Azathioprine oral tab 50 MG					
K0120	N	Azathioprine prentrl 100 MG					
K0121	N	Cyclosporine oral 25 MG					
K0122	N	Cyclosporine prentrl 250 MG					
K0123	N	Imun/antitymocyt glob 250 MG					
K0137	A	Skin barrier liquid per oz					
K0138	A	Skin barrier paste per oz					
K0139	A	Skin barrier powder per oz					
K0168	A	Disposable nebulizer set					
K0169	A	Disposable nebulizer small					
K0170	A	Non disposable nebulizer set					
K0171	A	Filtered nebulizer set					
K0172	A	Disposable nebulizer unfill					
K0173	A	Disposable nebulizer prefill					
K0174	A	Reservoir bottle w nebulizer					
K0175	A	Disposable corrugated tubing					
K0176	A	Non dispos corrugated tubing					
K0177	A	Water collec dev w nebulizer					
K0178	A	Disposbl filter w compressor					
K0179	A	Non-dispos filter w/compress					
K0180	A	Aerosol mask with nebulizer					
K0181	A	Dome & mouthpiece w/ nebuliz					
K0182	A	Water distilled w/ nebulizer					
K0183	A	Nasal application with cpap					
K0184	A	Nasal pillows/seals pair					
K0185	A	Headgear with cpap device					
K0186	A	Chin strap with cpap device					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
K0187	A	Tubing with cpap device					
K0188	A	Filter disposable with cpap					
K0189	A	Filter non-disposable w/cpap					
K0190	A	Disposable canister w/pump					
K0191	A	Non-disposbl canister w/pump					
K0192	A	Tubing used w/ suction pump					
K0193	A	Airway pressure dev/w hmdfer					
K0194	A	Assist device w/humidifier					
K0195	A	Elevating whlchair leg rests					
K0268	A	Humidifier with cpap device					
K0269	A	Aerosol compressor cpap dev					
K0270	A	Ultrasonic generator w nebul					
K0277	A	Skin barrier solid 4x4 equiv					
K0278	A	Skin barrier with flange					
K0279	A	Skin barrier extended wear					
K0280	A	Extension drainage tubing					
K0281	A	Lubricant catheter insertion					
K0283	A	Saline solution dispenser					
K0284	A	External infusion pump reuse					
K0400	A	Skin support attachment each					
K0401	A	Diabetic deluxe shoe					
K0407	A	Urinary cath skin attachment					
K0408	A	Urinary cath leg strap					
K0409	A	Sterile H2O irrigation solut					
K0410	A	Male ext cath w/adh coating					
K0411	A	Male ext cath w/adh strip					
K0412	N	Mycophenolate mofetil 25o mg					
K0415	N	RX antiemetic drg, oral NOS					
K0416	N	Rx antiemetic drg,rectal NOS					
K0417	A	Mech infus pump sht trm drug					
K0418	N	Oral cyclosporin					
K0419	A	Drainable plstic pch w fcplt					
K0420	A	Drainable rubber pch w fcplt					
K0421	A	drainable plstic pch w/o fp					
K0422	A	Drainable rubber pch w/o fp					
K0423	A	Urinary plstic pouch w fcplt					
K0424	A	Urinary rubber pouch w fcplt					
K0425	A	Urinary plstic pouch w/o fp					
K0426	A	Urinary hvy plstc pch w/o fp					
K0427	A	Urinary rubber pouch w/o fp					
K0428	A	Ostomy faceplt/silicone ring					
K0429	A	Skin barrier solid ext wear					
K0430	A	Skin barrier w flang ex wear					
K0431	A	Closed pouch w st wear bar					
K0432	A	Drainable pch w ex wear bar					
K0433	A	Drainable pch w st wear bar					
K0434	A	Drainable pch ex wear convex					
K0435	A	Urinary pouch w ex wear bar					
K0436	A	Urinary pouch w st wear bar					
K0437	A	Urine pch w ex wear bar conv					
K0438	A	Ostomy pouch liq deodorant					
K0439	A	Ostomy pouch solid deodorant					
K0440	A	Nasal prosthesis					
K0441	A	Midfacial prosthesis					
K0442	A	Orbital prosthesis					
K0443	A	Upper facial prosthesis					
K0444	A	Hemi-facial prosthesis					
K0445	S	Auricular prosthesis	031	1.33	$70.52	$14.10	$14.10
K0446	A	Partial facial prosthesis					
K0447	A	Nasal septal prosthesis					
K0448	A	Unspec maxillofacial prosth					
K0449	A	Repair maxillofacial prosth					
K0450	A	Liq adhes for facial prosth					
K0451	A	Adhesive remover wipes					
K0452	A	Wheelchair bearings					
K0453	N	Amphotericin B					
K0455	A	Pump uninterrupted infusion					
K0501	A	Aerosol compressor for svneb					
K0503	A	Acetylcysteine inh sol u d					
K0504	A	Albuterol inh sol con					
K0505	A	Albuterol inh sol u d					
K0506	A	Atropine inh sol con					
K0507	A	Atropine inh sol u d					
K0508	A	Bitolterol mes inh sol con					
K0509	A	Bitolterol mes inh sol u d					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
K0511	A	Cromolyn sodium inh sol u d					
K0512	A	Dexamethasone inh sol con					
K0513	A	Dexamethasone inh sol u d					
K0514	A	Dornase alpha inh sol u d					
K0515	A	Glycopyrrolate inh sol con					
K0516	A	Glycopyrrolate inh sol u d					
K0518	A	Ipratropium brom inh sol u d					
K0519	A	Isoetharine HCl inh sol con					
K0520	A	Isoetharine HCl inh sol u d					
K0521	A	IsoproterenolHCl inh sol con					
K0522	A	IsoproterenolHCl inh sol u d					
K0523	A	Metaproterenol inh sol con					
K0524	A	Metaproterenol inh sol u d					
K0525	A	Terbutaline SO4 inh sol con					
K0526	A	Terbutaline SO4 inh sol u d					
K0527	A	Triamcinolone inh sol con					
K0528	A	Triamcinolone inh sol u d					
K0529	A	Sterile H20 or nss w lv neb					
K0530	A	Nebulizer not used w oxygen					
L0100	A	Cerv craniosten helmet mold					
L0110	A	Cerv craniostenosis hel non-					
L0120	A	Cerv flexible non-adjustable					
L0130	A	Flex thermoplastic collar mo					
L0140	A	Cervical semi-rigid adjustab					
L0150	A	Cerv semi-rig adj molded chn					
L0160	A	Cerv semi-rig wire occ/mand					
L0170	A	Cervical collar molded to pt					
L0172	A	Cerv col thermplas foam 2 pi					
L0174	A	Cerv col foam 2 piece w thor					
L0180	A	Cer post col occ/man sup adj					
L0190	A	Cerv collar supp adj cerv ba					
L0200	A	Cerv col supp adj bar & thor					
L0210	A	Thoracic rib belt					
L0220	A	Thor rib belt custom fabrica					
L0300	A	TLSO flex surgical support					
L0310	A	Tlso flexible custom fabrica					
L0315	A	Tlso flex elas rigid post pa					
L0317	A	Tlso flex hypext elas post p					
L0320	A	Tlso a–p contrl w apron frnt					
L0330	A	Tlso ant-pos-lateral control					
L0340	A	Tlso a-p-l-rotary with apron					
L0350	A	Tlso flex compress jacket cu					
L0360	A	Tlso flex compress jacket mo					
L0370	A	Tlso a-p-l-rotary hyperexten					
L0380	A	Tlso a-p-l-rot w/ pos extens					
L0390	A	Tlso a-p-l control molded					
L0400	A	Tlso a-p-l w interface mater					
L0410	A	Tlso a-p-l two piece constr					
L0420	A	Tlso a-p-l 2 piece w interfa					
L0430	A	Tlso a-p-l w interface custm					
L0440	A	Tlso a-p-l overlap frnt cust					
L0500	A	Lso flex surgical support					
L0510	A	Lso flexible custom fabricat					
L0515	A	Lso flex elas w/ rig post pa					
L0520	A	Lso a-p-l control with apron					
L0530	A	Lso ant-pos control w apron					
L0540	A	Lso lumbar flexion a-p-l					
L0550	A	Lso a-p-l control molded					
L0560	A	Lso a-p-l w interface					
L0565	A	Lso a-p-l control custom					
L0600	A	Sacroiliac flex surg support					
L0610	A	Sacroiliac flexible custm fa					
L0620	A	Sacroiliac semi-rig w apron					
L0700	A	Ctlso a-p-l control molded					
L0710	A	Ctlso a-p-l control w/ inter					
L0810	A	Halo cervical into jckt vest					
L0820	A	Halo cervical into body jack					
L0830	A	Halo cerv into milwaukee typ					
L0860	A	Magnetic resonanc image comp					
L0900	A	Torso/ptosis support					
L0910	A	Torso & ptosis supp custm fa					
L0920	A	Torso/pendulous abd support					
L0930	A	Pendulous abdomen supp custm					
L0940	A	Torso/postsurgical support					
L0950	A	Post surg support custom fab					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
L0960	A	Post surgical support pads					
L0970	A	Tlso corset front					
L0972	A	Lso corset front					
L0974	A	Tlso full corset					
L0976	A	Lso full corset					
L0978	A	Axillary crutch extension					
L0980	A	Peroneal straps pair					
L0982	A	Stocking supp grips set of f					
L0984	A	Protective body sock each					
L0999	A	Add to spinal orthosis NOS					
L1000	A	Ctlso milwauke initial model					
L1010	A	Ctlso axilla sling					
L1020	A	Kyphosis pad					
L1025	A	Kyphosis pad floating					
L1030	A	Lumbar bolster pad					
L1040	A	Lumbar or lumbar rib pad					
L1050	A	Sternal pad					
L1060	A	Thoracic pad					
L1070	A	Trapezius sling					
L1080	A	Outrigger					
L1085	A	Outrigger bil w/ vert extens					
L1090	A	Lumbar sling					
L1100	A	Ring flange plastic/leather					
L1110	A	Ring flange plas/leather mol					
L1120	A	Covers for upright each					
L1200	A	Furnsh initial orthosis only					
L1210	A	Lateral thoracic extension					
L1220	A	Anterior thoracic extension					
L1230	A	Milwaukee type superstructur					
L1240	A	Lumbar derotation pad					
L1250	A	Anterior asis pad					
L1260	A	Anterior thoracic derotation					
L1270	A	Abdominal pad					
L1280	A	Rib gusset (elastic) each					
L1290	A	Lateral trochanteric pad					
L1300	A	Body jacket mold to patient					
L1310	A	Post-operative body jacket					
L1499	A	Spinal orthosis NOS					
L1500	A	Thkao mobility frame					
L1510	A	Thkao standing frame					
L1520	A	Thkao swivel walker					
L1600	A	Abduct hip flex frejka w cvr					
L1610	A	Abduct hip flex frejka covr					
L1620	A	Abduct hip flex pavlik harne					
L1630	A	Abduct control hip semi-flex					
L1640	A	Pelv band/spread bar thigh c					
L1650	A	HO abduction hip adjustable					
L1660	A	HO abduction static plastic					
L1680	A	Pelvic & hip control thigh c					
L1685	A	Post-op hip abduct custom fa					
L1686	A	HO post-op hip abduction					
L1700	A	Leg perthes orth toronto typ					
L1710	A	Legg perthes orth newington					
L1720	A	Legg perthes orthosis trilat					
L1730	A	Legg perthes orth scottish r					
L1750	A	Legg perthes sling					
L1755	A	Legg perthes patten bottom t					
L1800	A	Knee orthoses elas w stays					
L1810	A	Ko elastic with joints					
L1815	A	Elastic with condylar pads					
L1820	A	Ko elas w/ condyle pads & jo					
L1825	A	Ko elastic knee cap					
L1830	A	Ko immobilizer canvas longit					
L1832	A	KO adj jnt pos rigid support					
L1834	A	Ko w/0 joint rigid molded to					
L1840	A	Ko derot ant cruciate custom					
L1843	A	KO single upright custom fit					
L1844	A	Ko w/adj jt rot cntrl molded					
L1845	A	Ko w/ adj flex/ext rotat cus					
L1846	A	Ko w adj flex/ext rotat mold					
L1850	A	Ko swedish type					
L1855	A	Ko plas doub upright jnt mol					
L1858	A	Ko polycentric pneumatic pad					
L1860	A	Ko supracondylar socket mold					
L1870	A	Ko doub upright lacers molde					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
L1880	A	Ko doub upright cuffs/lacers					
L1885	A	Knee upright w/resistance					
L1900	A	Afo sprng wir drsflx calf bd					
L1902	A	Afo ankle gauntlet					
L1904	A	Afo molded ankle gauntlet					
L1906	A	Afo multiligamentus ankle su					
L1910	A	Afo sing bar clasp attach sh					
L1920	A	Afo sing upright w/ adjust s					
L1930	A	Afo plastic					
L1940	A	Afo molded to patient plasti					
L1945	A	Afo molded plas rig ant tib					
L1950	A	Afo spiral molded to pt plas					
L1960	A	Afo pos solid ank plastic mo					
L1970	A	Afo plastic molded w/ankle j					
L1980	A	Afo sing solid stirrup calf					
L1990	A	Afo doub solid stirrup calf					
L2000	A	Kafo sing fre stirr thi/calf					
L2010	A	Kafo sng solid stirrup w/o j					
L2020	A	Kafo dbl solid stirrup band/					
L2030	A	Kafo dbl solid stirrup w/o j					
L2035	A	KAFO plastic pediatric size					
L2036	A	Kafo plas doub free knee mol					
L2037	A	Kafo plas sing free knee mol					
L2038	A	Kafo w/o joint multi-axis an					
L2039	A	KAFO, plstic, medlat rotat con					
L2040	A	Hkafo torsion bil rot straps					
L2050	A	Hkafo torsion cable hip pelv					
L2060	A	Hkafo torsion ball bearing j					
L2070	A	Hkafo torsion unilat rot str					
L2080	A	Hkafo unilat torsion cable					
L2090	A	Hkafo unilat torsion ball br					
L2102	A	Afo tibial fx cast plstr mol					
L2104	A	Afo tib fx cast synthetic mo					
L2106	A	Afo tib fx cast plaster mold					
L2108	A	Afo tib fx cast molded to pt					
L2112	A	Afo tibial fracture soft					
L2114	A	Afo tib fx semi-rigid					
L2116	A	Afo tibial fracture rigid					
L2122	A	Kafo fem fx cast plaster mol					
L2124	A	Kafo fem fx cast synthet mol					
L2126	A	Kafo fem fx cast thermoplas					
L2128	A	Kafo fem fx cast molded to p					
L2132	A	Kafo femoral fx cast soft					
L2134	A	Kafo fem fx cast semi-rigid					
L2136	A	Kafo femoral fx cast rigid					
L2180	A	Plas shoe insert w ank joint					
L2182	A	Drop lock knee					
L2184	A	Limited motion knee joint					
L2186	A	Adj motion knee jnt lerman t					
L2188	A	Quadrilateral brim					
L2190	A	Waist belt					
L2192	A	Pelvic band & belt thigh fla					
L2200	A	Limited ankle motion ea jnt					
L2210	A	Dorsiflexion assist each joi					
L2220	A	Dorsi & plantar flex ass/res					
L2230	A	Split flat caliper stirr & p					
L2240	A	Round caliper and plate atta					
L2250	A	Foot plate molded stirrup at					
L2260	A	Reinforced solid stirrup					
L2265	A	Long tongue stirrup					
L2270	A	Varus/valgus strap padded/li					
L2275	A	Plastic mod low ext pad/line					
L2280	A	Molded inner boot					
L2300	A	Abduction bar jointed adjust					
L2310	A	Abduction bar-straight					
L2320	A	Non-molded lacer					
L2330	A	Lacer molded to patient mode					
L2335	A	Anterior swing band					
L2340	A	Pre-tibial shell molded to p					
L2350	A	Prosthetic type socket molde					
L2360	A	Extended steel shank					
L2370	A	Patten bottom					
L2375	A	Torsion ank & half solid sti					
L2380	A	Torsion straight knee joint					
L2385	A	Straight knee joint heavy du					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
L2390	A	Offset knee joint each					
L2395	A	Offset knee joint heavy duty					
L2397	A	Suspension sleeve lower ext					
L2405	A	Knee joint drop lock ea jnt					
L2415	A	Knee joint cam lock each joi					
L2425	A	Knee disc/dial lock/adj flex					
L2430	A	Knee jnt ratchet lock ea jnt					
L2435	A	Knee joint polycentric joint					
L2492	A	Knee lift loop drop lock rin					
L2500	A	Thi/glut/ischia wgt bearing					
L2510	A	Th/wght bear quad-lat brim m					
L2520	A	Th/wght bear quad-lat brim c					
L2525	A	Th/wght bear nar m-l brim mo					
L2526	A	Th/wght bear nar m-l brim cu					
L2530	A	Thigh/wght bear lacer non-mo					
L2540	A	Thigh/wght bear lacer molded					
L2550	A	Thigh/wght bear high roll cu					
L2570	A	Hip clevis type 2 posit jnt					
L2580	A	Pelvic control pelvic sling					
L2600	A	Hip clevis/thrust bearing fr					
L2610	A	Hip clevis/thrust bearing lo					
L2620	A	Pelvic control hip heavy dut					
L2622	A	Hip joint adjustable flexion					
L2624	A	Hip adj flex ext abduct cont					
L2627	A	Plastic mold recipro hip & c					
L2628	A	Metal frame recipro hip & ca					
L2630	A	Pelvic control band & belt u					
L2640	A	Pelvic control band & belt b					
L2650	A	Pelv & thor control gluteal					
L2660	A	Thoracic control thoracic ba					
L2670	A	Thorac cont paraspinal uprig					
L2680	A	Thorac cont lat support upri					
L2750	A	Plating chrome/nickel pr bar					
L2755	A	Carbon graphite lamination					
L2760	A	Extension per extension per					
L2770	A	Low ext orthosis per bar/jnt					
L2780	A	Non-corrosive finish					
L2785	A	Drop lock retainer each					
L2795	A	Knee control full kneecap					
L2800	A	Knee cap medial or lateral p					
L2810	A	Knee control condylar pad					
L2820	A	Soft interface below knee se					
L2830	A	Soft interface above knee se					
L2840	A	Tibial length sock fx or equ					
L2850	A	Femoral lgth sock fx or equa					
L2860	A	Torsion mechanism knee/ankle					
L2999	A	Lower extremity orthosis NOS					
L3000	A	Ft insert ucb berkeley shell					
L3001	A	Foot insert removmolded spe					
L3002	A	Foot insert plastazote or eq					
L3003	A	Foot insert silicone gel eac					
L3010	A	Foot longitudinal arch suppo					
L3020	A	Foot longitud/metatarsal sup					
L3030	A	Foot arch support removprem					
L3040	A	Ft arch suprt premold longit					
L3050	A	Foot arch supp premold metat					
L3060	A	Foot arch supp longitud/meta					
L3070	A	Arch suprt att to sho longit					
L3080	A	Arch supp att to shoe metata					
L3090	A	Arch supp att to shoe long/m					
L3100	A	Hallus-valgus nght dynamic s					
L3140	A	Abduction rotation bar shoe					
L3150	A	Abduct rotation bar w/o shoe					
L3160	A	Shoe styled positioning dev					
L3170	A	Foot plastic heel stabilizer					
L3201	A	Oxford w supinat/pronat inf					
L3202	A	Oxford w/ supinat/pronator c					
L3203	A	Oxford w/ supinator/pronator					
L3204	A	Hightop w/ supp/pronator inf					
L3206	A	Hightop w/ supp/pronator chi					
L3207	A	Hightop w/ supp/pronator jun					
L3208	A	Surgical boot each infant					
L3209	A	Surgical boot each child					
L3211	A	Surgical boot each junior					
L3212	A	Benesch boot pair infant					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
L3213	A	Benesch boot pair child					
L3214	A	Benesch boot pair junior					
L3215	A	Orthopedic ftwear ladies oxf					
L3216	A	Orthoped ladies shoes dpth i					
L3217	A	Ladies shoes hightop depth i					
L3218	A	Ladies surgical boot each					
L3219	A	Orthopedic mens shoes oxford					
L3221	A	Orthopedic mens shoes dpth i					
L3222	A	Mens shoes hightop depth inl					
L3223	A	Mens surgical boot each					
L3224	A	Woman's shoe oxford brace					
L3225	A	Man's shoe oxford brace					
L3230	A	Custom shoes depth inlay					
L3250	A	Custom mold shoe remov prost					
L3251	A	Shoe molded to pt silicone s					
L3252	A	Shoe molded plastazote cust					
L3253	A	Shoe molded plastazote cust					
L3254	A	Orth foot non-stndard size/w					
L3255	A	Orth foot non-standard size/					
L3257	A	Orth foot add charge split s					
L3260	A	Ambulatory surgical boot eac					
L3265	A	Plastazote sandal each					
L3300	A	Sho lift taper to metatarsal					
L3310	A	Shoe lift elev heel/sole neo					
L3320	A	Shoe lift elev heel/sole cor					
L3330	A	Lifts elevation metal extens					
L3332	A	Shoe lifts tapered to one-ha					
L3334	A	Shoe lifts elevation heel /i					
L3340	A	Shoe wedge sach					
L3350	A	Shoe heel wedge					
L3360	A	Shoe sole wedge outside sole					
L3370	A	Shoe sole wedge between sole					
L3380	A	Shoe clubfoot wedge					
L3390	A	Shoe outflare wedge					
L3400	A	Shoe metatarsal bar wedge ro					
L3410	A	Shoe metatarsal bar between					
L3420	A	Full sole/heel wedge btween					
L3430	A	Sho heel count plast reinfor					
L3440	A	Heel leather reinforced					
L3450	A	Shoe heel sach cushion type					
L3455	A	Shoe heel new leather standa					
L3460	A	Shoe heel new rubber standar					
L3465	A	Shoe heel thomas with wedge					
L3470	A	Shoe heel thomas extend to b					
L3480	A	Shoe heel pad & depress for					
L3485	A	Shoe heel pad removable for					
L3500	A	Shoe misc add insole leather					
L3510	A	Shoe misc addition insole ru					
L3520	A	Shoe insole felt cver w/ lea					
L3530	A	Shoe misc additions sole hal					
L3540	A	Shoe misc additions sole ful					
L3550	A	Shoe misc add toe tap standa					
L3560	A	Shoe misc add toe tap horses					
L3570	A	Shoe special extension to in					
L3580	A	Shoe convert instep velcro c					
L3590	A	Shoe convert firm to soft cn					
L3595	A	Shoe misc additions march ba					
L3600	A	Trans shoe calip plate exist					
L3610	A	Trans shoe caliper plate new					
L3620	A	Trans shoe solid stirrup exi					
L3630	A	Trans shoe solid stirrup new					
L3640	A	Shoe dennis browne splint bo					
L3649	A	Unlist proc orth shoe modif/					
L3650	A	Shlder fig 8 abduct restrain					
L3660	A	Abduct restrainer canvas & web					
L3670	A	Acromio/clavicular canvas & we					
L3700	A	Elbow orthoses elas w stays					
L3710	A	Elbow elastic with metal joi					
L3720	A	Forearm/arm cuffs free motio					
L3730	A	Forearm/arm cuffs ext/flex a					
L3740	A	Cuffs adj lock w/ active con					
L3800	A	Whfo short opponen no attach					
L3805	A	Whfo long opponens no attach					
L3810	A	Whfo thumb abduction bar					
L3815	A	Whfo second m.p. abduction a					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
L3820	A	Whfo ip ext asst w/ mp ext s					
L3825	A	Whfo m.p. extension stop					
L3830	A	Whfo m.p. extension assist					
L3835	A	Whfo m.p. spring extension a					
L3840	A	Whfo spring swivel thumb					
L3845	A	Whfo thumb ip ext ass w/ mp					
L3850	A	Action wrist w/ dorsiflex as					
L3855	A	Whfo adj m.p. flexion contro					
L3860	A	Whfo adj m.p. flex ctrl & i					
L3890	A	Torsion mechanism wrist/elbo					
L3900	A	Hinge extension/flex wrist/f					
L3901	A	Hinge ext/flex wrist finger					
L3902	A	Whfo ext power compress gas					
L3904	A	Whfo electric custom fitted					
L3906	A	Wrist gauntlet molded to pt					
L3907	A	Whfo wrst gauntlt thmb spica					
L3908	A	Wrist cock-up non-molded					
L3910	A	Whfo swanson design					
L3912	A	Flex glove w/elastic finger					
L3914	A	WHO wrist extension cock-up					
L3916	A	Whfo wrist extens w/ outrigg					
L3918	A	HFO knuckle bender					
L3920	A	Knuckle bender with outrigge					
L3922	A	Knuckle bend 2 seg to flex j					
L3924	A	Oppenheimer					
L3926	A	Thomas suspension					
L3928	A	Finger extension w/ clock sp					
L3930	A	Finger extension with wrist					
L3932	A	Safety pin spring wire					
L3934	A	Safety pin modified					
L3936	A	Palmer					
L3938	A	Dorsal wrist					
L3940	A	Dorsal wrist w/outrigger at					
L3942	A	Reverse knuckle bender					
L3944	A	Reverse knuckle bend w/ outr					
L3946	A	HFO composite elastic					
L3948	A	Finger knuckle bender					
L3950	A	Oppenheimer w/ knuckle bend					
L3952	A	Oppenheimer w/ rev knuckle 2					
L3954	A	Spreading hand					
L3956	A	Add joint upper ext orthosis					
L3960	A	Sewho airplan desig abdu pos					
L3962	A	Sewho erbs palsey design abd					
L3963	A	Molded w/ articulating elbow					
L3964	A	Seo mobile arm sup att to wc					
L3965	A	Arm supp att to wc rancho ty					
L3966	A	Mobile arm supports reclinin					
L3968	A	Friction dampening arm supp					
L3969	A	Monosuspension arm/hand supp					
L3970	A	Elevat proximal arm support					
L3972	A	Offset/lat rocker arm w/ ela					
L3974	A	Mobile arm support supinator					
L3980	A	Upp ext fx orthosis humeral					
L3982	A	Upper ext fx orthosis rad/ul					
L3984	A	Upper ext fx orthosis wrist					
L3985	A	Forearm hand fx orth w/ wr h					
L3986	A	Humeral rad/ulna wrist fx or					
L3995	A	Sock fracture or equal each					
L3999	A	Upper limb orthosis NOS					
L4000	A	Repl girdle milwaukee orth					
L4010	A	Replace trilateral socket br					
L4020	A	Replace quadlat socket brim					
L4030	A	Replace socket brim cust fit					
L4040	A	Replace molded thigh lacer					
L4045	A	Replace non-molded thigh lac					
L4050	A	Replace molded calf lacer					
L4055	A	Replace non-molded calf lace					
L4060	A	Replace high roll cuff					
L4070	A	Replace prox & dist upright					
L4080	A	Repl met band kafo-afo prox					
L4090	A	Repl met band kafo-afo calf/					
L4100	A	Repl leath cuff kafo prox th					
L4110	A	Repl leath cuff kafo-afo cal					
L4130	A	Replace pretibial shell					
L4205	A	Ortho dvc repair per 15 min					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
L4210	A	Orth dev repair/repl minor p					
L4310	A	Mult-podus/eq orth prep mgmt					
L4320	A	Low ext mgmt sys ft pos afo					
L4350	A	Pneumatic ankle cntrl splint					
L4360	A	Pneumatic walking splint					
L4370	A	Pneumatic full leg splint					
L4380	A	Pneumatic knee splint					
L4390	A	Replace multi-podus splint					
L4392	A	Replace ankle contrac splint					
L4394	A	Replace foot drop splint					
L4396	A	Ankle contracture splint					
L4398	A	Foot drop splint recumbent					
L5000	A	Sho insert w arch toe filler					
L5010	A	Mold socket ank hgt w/ toe f					
L5020	A	Tibial tubercle hgt w/ toe f					
L5050	A	Ank symes mold sckt sach ft					
L5060	A	Symes met fr leath socket ar					
L5100	A	Molded socket shin sach foot					
L5105	A	Plast socket jts/thgh lacer					
L5150	A	Mold sckt ext knee shin sach					
L5160	A	Mold socket bent knee shin s					
L5200	A	Kne sing axis fric shin sach					
L5210	A	No knee/ankle joints w/ ft b					
L5220	A	No knee joint with artic ali					
L5230	A	Fem focal defic constant fri					
L5250	A	Hip canad sing axi cons fric					
L5270	A	Tilt table locking hip sing					
L5280	A	Hemipelvect canad sing axis					
L5300	A	Bk sach soft cover & finish					
L5310	A	Knee disart sach soft cv/fin					
L5320	A	Ak open end sach soft cv/fin					
L5330	A	Hip canadian sach sft cv/fin					
L5340	A	Hemipelvectomy canad cv/fin					
L5400	A	Postop dress & 1 cast chg bk					
L5410	A	Postop dsg bk ea add cast ch					
L5420	A	Postop dsg & 1 cast chg ak/d					
L5430	A	Postop dsg ak ea add cast ch					
L5450	A	Postop app non-wgt bear dsg					
L5460	A	Postop app non-wgt bear dsg					
L5500	A	Init bk ptb plaster direct					
L5505	A	Init ak ischal plstr direct					
L5510	A	Prep BK ptb plaster molded					
L5520	A	Prep BK ptb thermopls direct					
L5530	A	Prep BK ptb thermopls molded					
L5535	A	Prep BK ptb open end socket					
L5540	A	Prep BK ptb laminated socket					
L5560	A	Prep AK ischial plast molded					
L5570	A	Prep AK ischial direct form					
L5580	A	Prep AK ischial thermo mold					
L5585	A	Prep AK ischial open end					
L5590	A	Prep AK ischial laminated					
L5595	A	Hip disartic sach thermopls					
L5600	A	Hip disart sach laminat mold					
L5610	A	Above knee hydracadence					
L5611	A	Ak 4 bar link w/fric swing					
L5613	A	Ak 4 bar ling w/hydraul swig					
L5614	A	4-bar link above knee w/swng					
L5616	A	Ak univ multiplex sys frict					
L5617	A	AK/BK self-aligning unit ea					
L5618	A	Test socket symes					
L5620	A	Test socket below knee					
L5622	A	Test socket knee disarticula					
L5624	A	Test socket above knee					
L5626	A	Test socket hip disarticulat					
L5628	A	Test socket hemipelvectomy					
L5629	A	Below knee acrylic socket					
L5630	A	Syme typ expandabl wall sckt					
L5631	A	Ak/knee disartic acrylic soc					
L5632	A	Symes type ptb brim design s					
L5634	A	Symes type poster opening so					
L5636	A	Symes type medial opening so					
L5637	A	Below knee total contact					
L5638	A	Below knee leather socket					
L5639	A	Below knee wood socket					
L5640	A	Knee disarticulat leather so					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
L5642	A	Above knee leather socket					
L5643	A	Hip flex inner socket ext fr					
L5644	A	Above knee wood socket					
L5645	A	Ak flexibl inner socket ext					
L5646	A	Below knee air cushion socke					
L5647	A	Below knee suction socket					
L5648	A	Above knee air cushion socke					
L5649	A	Isch containmt/narrow m-l so					
L5650	A	Tot contact ak/knee disart s					
L5651	A	Ak flex inner socket ext fra					
L5652	A	Suction susp ak/knee disart					
L5653	A	Knee disart expand wall sock					
L5654	A	Socket insert symes					
L5655	A	Socket insert below knee					
L5656	A	Socket insert knee articulat					
L5658	A	Socket insert above knee					
L5660	A	Sock insrt syme silicone gel					
L5661	A	Multi-durometer symes					
L5662	A	Socket insert bk silicone ge					
L5663	A	Sock knee disartic silicone					
L5664	A	Socket insert ak silicone ge					
L5665	A	Multi-durometer below knee					
L5666	A	Below knee cuff suspension					
L5667	A	Socket insert w lock lower					
L5668	A	Socket insert w/o lock lower					
L5669	A	Below knee socket w/o lock					
L5670	A	Bk molded supracondylar susp					
L5672	A	Bk removable medial brim sus					
L5674	A	Bk latex sleeve suspension/e					
L5675	A	Bk latex sleeve susp/eq hvy					
L5676	A	Bk knee joints single axis p					
L5677	A	Bk knee joints polycentric p					
L5678	A	Bk joint covers pair					
L5680	A	Bk thigh lacer non-molded					
L5682	A	Bk thigh lacer glut/ischia m					
L5684	A	Bk fork strap					
L5686	A	Bk back check					
L5688	A	Bk waist belt webbing					
L5690	A	Bk waist belt padded and lin					
L5692	A	Ak pelvic control belt light					
L5694	A	Ak pelvic control belt pad/l					
L5695	A	Ak sleeve susp neoprene/equa					
L5696	A	Ak/knee disartic pelvic join					
L5697	A	Ak/knee disartic pelvic band					
L5698	A	Ak/knee disartic silesian ba					
L5699	A	Shoulder harness					
L5700	A	Replace socket below knee					
L5701	A	Replace socket above knee					
L5702	A	Replace socket hip					
L5704	A	Custom shape covr below knee					
L5705	A	Custm shape cover above knee					
L5706	A	Custm shape cvr knee disart					
L5707	A	Custm shape cover hip disart					
L5710	A	Kne-shin exo sng axi mnl loc					
L5711	A	Knee-shin exo mnl lock ultra					
L5712	A	Knee-shin exo frict swg & st					
L5714	A	Knee-shin exo variable frict					
L5716	A	Knee-shin exo mech stance ph					
L5718	A	Knee-shin exo frct swg & sta					
L5722	A	Knee-shin pneum swg frct exo					
L5724	A	Knee-shin exo fluid swing ph					
L5726	A	Knee-shin ext jnts fld swg e					
L5728	A	Knee-shin fluid swg & stance					
L5780	A	Knee-shin pneum/hydra pneum					
L5785	A	Exoskeletal bk ultralt mater					
L5790	A	Exoskeletal ak ultra-light m					
L5795	A	Exoskel hip ultra-light mate					
L5810	A	Endoskel knee-shin mnl lock					
L5811	A	Endo knee-shin mnl lck ultra					
L5812	A	Endo knee-shin frct swg & st					
L5814	A	Endo knee-shin hydral swg ph					
L5816	A	Endo knee-shin polyc mch sta					
L5818	A	Endo knee-shin frct swg & st					
L5822	A	Endo knee-shin pneum swg frc					
L5824	A	Endo knee-shin fluid swing p					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
L5826	A	Pediatric knee joint					
L5828	A	Endo knee-shin fluid swg/sta					
L5830	A	Endo knee-shin pneum/swg pha					
L5840	A	Multi-axial knee/shin system					
L5845	A	Knee-shin sys stance flexion					
L5846	A	Knee-shin sys microprocessor					
L5850	A	Endo ak/hip knee extens assi					
L5855	A	Mech hip extension assist					
L5910	A	Endo below knee alignable sy					
L5920	A	Endo ak/hip alignable system					
L5925	A	Above knee manual lock					
L5930	A	High activity knee frame					
L5940	A	Endo bk ultra-light material					
L5950	A	Endo ak ultra-light material					
L5960	A	Endo hip ultra-light materia					
L5962	A	Below knee flex cover system					
L5964	A	Above knee flex cover system					
L5966	A	Hip flexible cover system					
L5970	A	Foot external keel sach foot					
L5972	A	Flexible keel foot					
L5974	A	Foot single axis ankle/foot					
L5976	A	Energy storing foot					
L5978	A	Ft prosth multiaxial ankl/ft					
L5979	A	Multi-axial ankle/ft prosth					
L5980	A	Flex foot system					
L5981	A	Flex-walk sys low ext prosth					
L5982	A	Exoskeletal axial rotation u					
L5984	A	Endoskeletal axial rotation					
L5985	A	Lwr ext dynamic prosth pylon					
L5986	A	Multi-axial rotation unit					
L5987	A	Shank ft w vert load pylon					
L5999	A	Lowr extremity prosthes NOS					
L6000	A	Par hand robin-aids thum rem					
L6010	A	Hand robin-aids little/ring					
L6020	A	Part hand robin-aids no fing					
L6050	A	Wrst MLd sck flx hng tri pad					
L6055	A	Wrst mold sock w/exp interfa					
L6100	A	Elb mold sock flex hinge pad					
L6110	A	Elbow mold sock suspension t					
L6120	A	Elbow mold doub splt soc ste					
L6130	A	Elbow stump activated lock h					
L6200	A	Elbow mold outsid lock hinge					
L6205	A	Elbow molded w/ expand inter					
L6250	A	Elbow inter loc elbow forarm					
L6300	A	Shlder disart int lock elbow					
L6310	A	Shoulder passive restor comp					
L6320	A	Shoulder passive restor cap					
L6350	A	Thoracic intern lock elbow					
L6360	A	Thoracic passive restor comp					
L6370	A	Thoracic passive restor cap					
L6380	A	Postop dsg cast chg wrst/elb					
L6382	A	Postop dsg cast chg elb dis/					
L6384	A	Postop dsg cast chg shlder/t					
L6386	A	Postop ea cast chg & realign					
L6388	A	Postop applicat rigid dsg on					
L6400	A	Below elbow prosth tiss shap					
L6450	A	Elb disart prosth tiss shap					
L6500	A	Above elbow prosth tiss shap					
L6550	A	Shldr disar prosth tiss shap					
L6570	A	Scap thorac prosth tiss shap					
L6580	A	Wrist/elbow bowden cable mol					
L6582	A	Wrist/elbow bowden cbl dir f					
L6584	A	Elbow fair lead cable molded					
L6586	A	Elbow fair lead cable dir fo					
L6588	A	Shdr fair lead cable molded					
L6590	A	Shdr fair lead cable direct					
L6600	A	Polycentric hinge pair					
L6605	A	Single pivot hinge pair					
L6610	A	Flexible metal hinge pair					
L6615	A	Disconnect locking wrist uni					
L6616	A	Disconnect insert locking wr					
L6620	A	Flexion-friction wrist unit					
L6623	A	Spring-ass rot wrst w/ latch					
L6625	A	Rotation wrst w/ cable lock					
L6628	A	Quick disconn hook adapter o					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
L6629	A	Lamination collar w/couplin					
L6630	A	Stainless steel any wrist					
L6632	A	Latex suspension sleeve each					
L6635	A	Lift assist for elbow					
L6637	A	Nudge control elbow lock					
L6640	A	Shoulder abduction joint pai					
L6641	A	Excursion amplifier pulley t					
L6642	A	Excursion amplifier lever ty					
L6645	A	Shoulder flexion-abduction j					
L6650	A	Shoulder universal joint					
L6655	A	Standard control cable extra					
L6660	A	Heavy duty control cable					
L6665	A	Teflon or equal cable lining					
L6670	A	Hook to hand cable adapter					
L6672	A	Harness chest/shlder saddle					
L6675	A	Harness figure of 8 sing con					
L6676	A	Harness figure of 8 dual con					
L6680	A	Test sock wrist disart/bel e					
L6682	A	Test sock elbw disart/above					
L6684	A	Test socket shldr disart/tho					
L6686	A	Suction socket					
L6687	A	Frame typ socket bel elbow/w					
L6688	A	Frame typ sock above elb/dis					
L6689	A	Frame typ socket shoulder di					
L6690	A	Frame typ sock interscap-tho					
L6691	A	Removable insert each					
L6692	A	Silicone gel insert or equal					
L6700	A	Terminal device model #3					
L6705	A	Terminal device model #5					
L6710	A	Terminal device model #5x					
L6715	A	Terminal device model #5xa					
L6720	A	Terminal device model #6					
L6725	A	Terminal device model #7					
L6730	A	Terminal device model #7lo					
L6735	A	Terminal device model #8					
L6740	A	Terminal device model #8x					
L6745	A	Terminal device model #88x					
L6750	A	Terminal device model #10p					
L6755	A	Terminal device model #10x					
L6765	A	Terminal device model #12p					
L6770	A	Terminal device model #99x					
L6775	A	Terminal device model#555					
L6780	A	Terminal device model #ss555					
L6790	A	Hooks-accu hook or equal					
L6795	A	Hooks-2 load or equal					
L6800	A	Hooks-aprl vc or equal					
L6805	A	Modifier wrist flexion unit					
L6806	A	Trs grip vc or equal					
L6807	A	Term device grip1/2 or equal					
L6808	A	Term device infant or child					
L6809	A	Trs super sport passive					
L6810	A	Pincher tool otto bock or eq					
L6825	A	Hands dorrance vo					
L6830	A	Hand aprl vc					
L6835	A	Hand sierra vo					
L6840	A	Hand becker imperial					
L6845	A	Hand becker lock grip					
L6850	A	Term dvc-hand becker plylite					
L6855	A	Hand robin-aids vo					
L6860	A	Hand robin-aids vo soft					
L6865	A	Hand passive hand					
L6867	A	Hand detroit infant hand					
L6868	A	Passive inf hand steeper/hos					
L6870	A	Hand child mitt					
L6872	A	Hand nyu child hand					
L6873	A	Hand mech inf steeper or equ					
L6875	A	Hand bock vc					
L6880	A	Hand bock vo					
L6890	A	Production glove					
L6895	A	Custom glove					
L6900	A	Hand restorat thumb/1 finger					
L6905	A	Hand restoration multiple fi					
L6910	A	Hand restoration no fingers					
L6915	A	Hand restoration replacmnt g					
L6920	A	Wrist disarticul switch ctrl					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
L6925	A	Wrist disart myoelectronic c					
L6930	A	Below elbow switch control					
L6935	A	Below elbow myoelectronic ct					
L6940	A	Elbow disarticulation switch					
L6945	A	Elbow disart myoelectronic c					
L6950	A	Above elbow switch control					
L6955	A	Above elbow myoelectronic ct					
L6960	A	Shldr disartic switch contro					
L6965	A	Shldr disartic myoelectronic					
L6970	A	Interscapular-thor switch ct					
L6975	A	Interscap-thor myoelectronic					
L7010	A	Hand otto back steeper/eq sw					
L7015	A	Hand sys teknik village swit					
L7020	A	Electronic greifer switch ct					
L7025	A	Electron hand myoelectronic					
L7030	A	Hand sys teknik vill myoelec					
L7035	A	Electron greifer myoelectro					
L7040	A	Prehensile actuator hosmer s					
L7045	A	Electron hook child michigan					
L7170	A	Electronic elbow hosmer swit					
L7180	A	Electronic elbow utah myoele					
L7185	A	Electron elbow adolescent sw					
L7186	A	Electron elbow child switch					
L7190	A	Elbow adolescent myoelectron					
L7191	A	Elbow child myoelectronic ct					
L7260	A	Electron wrist rotator otto					
L7261	A	Electron wrist rotator utah					
L7266	A	Servo control steeper or equ					
L7272	A	Analogue control unb or equa					
L7274	A	Proportional ctl 12 volt uta					
L7360	A	Six volt bat otto bock/eq ea					
L7362	A	Battery chrgr six volt otto					
L7364	A	Twelve volt battery utah/equ					
L7366	A	Battery chrgr 12 volt utah/e					
L7499	A	Upper extremity prosthes NOS					
L7500	A	Prosthetic dvc repair hourly					
L7510	A	Prosthetic device repair rep					
L7520	A	Repair prosthesis per 15 min					
L7900	A	Vacuum erection system					
L8000	A	Mastectomy bra					
L8010	A	Mastectomy sleeve					
L8020	A	Mastectomy form					
L8030	A	Breast prosthesis silicone/e					
L8039	A	Breast prosthesis NOS					
L8100	A	Elas suprt stock bk med wgt					
L8110	A	Elastic supp stocking bk hvy					
L8120	A	Elastic supp stockng bk surg					
L8130	A	Elastic supp stocking ak med					
L8140	A	Elastic supp stocking ak hvy					
L8150	A	Elastic supp stockng ak surg					
L8160	A	Supp stocking full lgth med					
L8170	A	Supp stocking full lgth hvy					
L8180	A	Supp stocking heavy surg wei					
L8190	A	Elas stocking leotards med w					
L8200	A	Elas stocking leotards surg					
L8210	A	Elastic stocking custom made					
L8220	A	Elastic stocking lymphedema					
L8230	A	Elastic stocking garter belt					
L8239	A	Elastic support NOS					
L8300	A	Truss single w/ standard pad					
L8310	A	Truss double w/ standard pad					
L8320	A	Truss addition to std pad wa					
L8330	A	Truss add to std pad scrotal					
L8400	A	Sheath below knee					
L8410	A	Sheath above knee					
L8415	A	Sheath upper limb					
L8417	A	Pros sheath/sock w gel cushn					
L8420	A	Sock wool below knee					
L8430	A	Sock wool above knee					
L8435	A	Sock wool upper limb					
L8440	A	Shrinker below knee					
L8460	A	Shrinker above knee					
L8465	A	Shrinker upper limb					
L8470	A	Stump sock single below knee					
L8480	A	Stump sock single above knee					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
L8485	A	Stump sock fitting uppr limb					
L8490	A	Air seal suction reten systm					
L8499	A	Unlisted misc prosthetic ser					
L8500	A	Artificial larynx					
L8501	A	Tracheostomy speaking valve					
L8600	A	Implant breast silicone/eq					
L8603	A	Collagen imp urinary 2.5 CC					
L8610	A	Ocular implant					
L8612	A	Aqueous shunt prosthesis					
L8613	A	Ossicular implant					
L8614	A	Cochlear device/system					
L8619	A	Replace cochlear processor					
L8630	A	Metacarpophalangeal implant					
L8641	A	Metatarsal joint implant					
L8642	A	Hallux implant					
L8658	A	Interphalangeal joint implnt					
L8670	A	Vascular graft, synthetic					
L8699	A	Prosthetic implant NOS					
M0064	X	Visit for drug monitoring	090	0.85	$45.05	$12.43	$9.01
M0075	E	Cellular therapy					
M0076	E	Prolotherapy					
M0100	E	Intragastric hypothermia					
M0101	E	Foot care hygienic/pm					
M0300	E	IV chelation therapy					
M0301	E	Fabric wrapping of aneurysm					
M0302	E	Assessment of cardiac output					
P2028	A	Cephalin floculation test					
P2029	A	Congo red blood test					
P2031	E	Hair analysis					
P2033	A	Blood thymol turbidity					
P2038	A	Blood mucoprotein					
P3000	A	Screen pap by tech w md supv					
P3001	A	Screening pap smear by phys					
P7001	E	Culture bacterial urine					
P9010	N	Whole blood for transfusion					
P9011	N	Blood split unit					
P9012	N	Cryoprecipitate each unit					
P9013	N	Unit/s blood fibrinogen					
P9014	N	Gamma globulin 1 ML					
P9015	N	Rh immune globulin 1 ML					
P9016	N	Leukocyte poor blood, unit					
P9017	N	One donor fresh frozn plasma					
P9018	N	Plasma protein fract, unit					
P9019	N	Platelet concentrate unit					
P9020	N	Platelet rich plasma unit					
P9021	N	Red blood cells unit					
P9022	N	Washed red blood cells unit					
P9603	N	One-way allow prorated miles					
P9604	N	One-way allow prorated trip					
P9610	E	Urine specimen collect singl					
P9615	E	Urine specimen collect mult					
Q0034	X	Admin of influenza vaccine	901	0.07	$3.92	$2.49	$.78
Q0035	X	Cardiokymography	950	0.35	$18.61	$15.82	$3.72
Q0068	T	Extracorpeal plasmapheresis	369	4.33	$229.19	$97.18	$45.84
Q0081	X	Infusion ther other than che	906	1.46	$77.38	$42.49	$15.48
Q0082	X	Activity therapy w/partial h					
Q0083	S	Chemo by other than infusion	987	0.65	$34.28	$13.33	$6.86
Q0084	S	Chemotherapy by infusion	989	1.72	$91.09	$40.68	$18.22
Q0085	S	Chemo by both infusion and o	989	1.72	$91.09	$40.68	$18.22
Q0086	A	Physical therapy evaluation/					
Q0091	T	Obtaining screen pap smear	561	1.52	$80.32	$24.63	$16.06
Q0092	N	Set up port xray equipment					
Q0111	A	Wet mounts/ w preparations					
Q0112	A	Potassium hydroxide preps					
Q0113	A	Pinworm examinations					
Q0114	A	Fern test					
Q0115	A	Post-coital mucous exam					
Q0132	A	Dispensing fee DME neb drug					
Q0136	N	Non esrd epoetin alpha inj					
Q0144	E	Azithromycin dihydrate, oral					
Q0156	N	Human albumin 5%					
Q0157	N	Human albumin 25%					
Q9920	A	Epoetin with hct <= 20					
Q9921	A	Epoetin with hct = 21					
Q9922	A	Epoetin with hct = 22					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
Q9923	A	Epoetin with hct = 23					
Q9924	A	Epoetin with hct = 24					
Q9925	A	Epoetin with hct = 25					
Q9926	A	Epoetin with hct = 26					
Q9927	A	Epoetin with hct = 27					
Q9928	A	Epoetin with hct = 28					
Q9929	A	Epoetin with hct = 29					
Q9930	A	Epoetin with hct = 30					
Q9931	A	Epoetin with hct = 31					
Q9932	A	Epoetin with hct = 32					
Q9933	A	Epoetin with hct = 33					
Q9934	A	Epoetin with hct = 34					
Q9935	A	Epoetin with hct = 35					
Q9936	A	Epoetin with hct = 36					
Q9937	A	Epoetin with hct = 37					
Q9938	A	Epoetin with hct = 38					
Q9939	A	Epoetin with hct = 39					
Q9940	A	Epoetin with hct >= 40					
R0070	N	Transport portable x-ray					
R0075	N	Transport port x-ray multipl					
R0076	N	Transport portable EKG					
V2020	A	Vision svcs frames purchases					
V2025	E	Eyeglasses delux frames					
V2100	A	Lens spher single plano 4.00					
V2101	A	Single visn sphere 4.12–7.00					
V2102	A	Singl visn sphere 7.12–20.00					
V2103	A	Spherocylindr 4.00d/12–2.00d					
V2104	A	Spherocylindr 4.00d/2.12–4d					
V2105	A	Spherocylinder 4.00d/4.25–6d					
V2106	A	Spherocylinder 4.00d/>6.00d					
V2107	A	Spherocylinder 4.25d/12–2d					
V2108	A	Spherocylinder 4.25d/2.12–4d					
V2109	A	Spherocylinder 4.25d/4.25–6d					
V2110	A	Spherocylinder 4.25d/over 6d					
V2111	A	Spherocylindr 7.25d/.25–2.25					
V2112	A	Spherocylindr 7.25d/2.25–4d					
V2113	A	Spherocylindr 7.25d/4.25–6d					
V2114	A	Spherocylinder over 12.00d					
V2115	A	Lens lenticular bifocal					
V2116	A	Nonaspheric lens bifocal					
V2117	A	Aspheric lens bifocal					
V2118	A	Lens aniseikonic single					
V2199	A	Lens single vision not oth c					
V2200	A	Lens spher bifoc plano 4.00d					
V2201	A	Lens sphere bifocal 4.12–7.0					
V2202	A	Lens sphere bifocal 7.12–20					
V2203	A	Lens sphcyl bifocal 4.00d/.1					
V2204	A	Lens sphcy bifocal 4.00d/2.1					
V2205	A	Lens sphcy bifocal 4.00d/4.2					
V2206	A	Lens sphcy bifocal 4.00d/ove					
V2207	A	Lens sphcy bifocal 4.25–7d/					
V2208	A	Lens sphcy bifocal 4.25–7/2					
V2209	A	Lens sphcy bifocal 4.25–7/4					
V2210	A	Lens sphcy bifocal 4.25–7/ov					
V2211	A	Lens sphcy bifo 7.25–12/.25–					
V2212	A	Lens sphcyl bifo 7.25–12/2.2					
V2213	A	Lens sphcyl bifo 7.25–12/4.2					
V2214	A	Lens sphcyl bifocal over 12					
V2215	A	Lens lenticular bifocal					
V2216	A	Lens lenticular nonaspheric					
V2217	A	Lens lenticular aspheric bif					
V2218	A	Lens aniseikonic bifocal					
V2219	A	Lens bifocal seg width over					
V2220	A	Lens bifocal add over 3.25d					
V2299	A	Lens bifocal speciality					
V2300	A	Lens sphere trifocal 4.00d					
V2301	A	Lens sphere trifocal 4.12–7					
V2302	A	Lens sphere trifocal 7.12–20					
V2303	A	Lens sphcy trifocal 4.0/.12–					
V2304	A	Lens sphcy trifocal 4.0/2.25					
V2305	A	Lens sphcy trifocal 4.0/4.25					
V2306	A	Lens sphcyl trifocal 4.00/>6					
V2307	A	Lens sphcy trifocal 4.25–7/					
V2308	A	Lens sphc trifocal 4.25–7/2					
V2309	A	Lens sphc trifocal 4.25–7/4					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
V2310	A	Lens sphc trifocal 4.25–7/>6					
V2311	A	Lens sphc trifo 7.25–12/.25–					
V2312	A	Lens sphc trifo 7.25–12/2.25					
V2313	A	Lens sphc trifo 7.25–12/4.25					
V2314	A	Lens sphcyl trifocal over 12					
V2315	A	Lens lenticular trifocal					
V2316	A	Lens lenticular nonaspheric					
V2317	A	Lens lenticular aspheric tri					
V2318	A	Lens aniseikonic trifocal					
V2319	A	Lens trifocal seg width > 28					
V2320	A	Lens trifocal add over 3.25d					
V2399	A	Lens trifocal speciality					
V2410	A	Lens variab asphericity sing					
V2430	A	Lens variable asphericity bi					
V2499	A	Variable asphericity lens					
V2500	A	Contact lens pmma spherical					
V2501	A	Cntct lens pmma-toric/prism					
V2502	A	Contact lens pmma bifocal					
V2503	A	Cntct lens pmma color vision					
V2510	A	Cntct gas permeable sphericl					
V2511	A	Cntct toric prism ballast					
V2512	A	Cntct lens gas permbl bifocl					
V2513	A	Contact lens extended wear					
V2520	A	Contact lens hydrophilic					
V2521	A	Cntct lens hydrophilic toric					
V2522	A	Cntct lens hydrophil bifocl					
V2523	A	Cntct lens hydrophil extend					
V2530	A	Contact lens gas impermeable					
V2531	A	Contact lens gas permeable					
V2599	A	Contact lens/es other type					
V2600	A	Hand held low vision aids					
V2610	A	Single lens spectacle mount					
V2615	A	Telescop/othr compound lens					
V2623	A	Plastic eye prosth custom					
V2624	A	Polishing artifical eye					
V2625	A	Enlargemnt of eye prosthesis					
V2626	A	Reduction of eye prosthesis					
V2627	A	Scleral cover shell					
V2628	A	Fabrication & fitting					
V2629	A	Prosthetic eye other type					
V2630	N	Anter chamber intraocul lens					
V2631	N	Iris support intraoclr lens					
V2632	N	Post chmbr intraocular lens					
V2700	A	Balance lens					
V2710	A	Glass/plastic slab off prism					
V2715	A	Prism lens/es					
V2718	A	Fresnell prism press-on lens					
V2730	A	Special base curve					
V2740	A	Rose tint plastic					
V2741	A	Non-rose tint plastic					
V2742	A	Rose tint glass					
V2743	A	Non-rose tint glass					
V2744	A	Tint photochromatic lens/es					
V2750	A	Anti-reflective coating					
V2755	A	UV lens/es					
V2760	A	Scratch resistant coating					
V2770	A	Occluder lens/es					
V2780	A	Oversize lens/es					
V2781	A	Progressive lens per lens					
V2785	N	Corneal tissue processing					
V2799	A	Miscellaneous vision service					
V5008	E	Hearing screening					
V5010	E	Assessment for hearing aid					
V5011	E	Hearing aid fitting/checking					
V5014	E	Hearing aid repair/modifying					
V5020	E	Conformity evaluation					
V5030	E	Body-worn hearing aid air					
V5040	E	Body-worn hearing aid bone					
V5050	E	Body-worn hearing aid in ear					
V5060	E	Behind ear hearing aid					
V5070	E	Glasses air conduction					
V5080	E	Glasses bone conduction					
V5090	E	Hearing aid dispensing fee					
V5100	E	Body-worn bilat hearing aid					
V5110	E	Hearing aid dispensing fee					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
V5120	E	Body-worn binaur hearing aid					
V5130	E	In ear binaural hearing aid					
V5140	E	Behind ear binaur hearing ai					
V5150	E	Glasses binaural hearing aid					
V5160	E	Dispensing fee binaural					
V5170	E	Within ear cros hearing aid					
V5180	E	Behind ear cros hearing aid					
V5190	E	Glasses cros hearing aid					
V5200	E	Cros hearing aid dispens fee					
V5210	E	In ear bicros hearing aid					
V5220	E	Behind ear bicros hearing ai					
V5230	E	Glasses bicros hearing aid					
V5240	E	Dispensing fee bicros					
V5299	A	Hearing service					
V5336	E	Repair communication device					
V5362	A	Speech screening					
V5363	A	Language screening					
V5364	A	Dysphagia screening					

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
031	Dental procedures		S	1.34	$67.90	$13.58	$13.58
031	D0150	Comprehensive oral evaluation					
031	D0240	Intraoral occlusal film					
031	D0250	Extraoral first film					
031	D0260	Extraoral ea additional film					
031	D0270	Dental bitewing single film					
031	D0272	Dental bitewings two films					
031	D0274	Dental bitewings four films					
031	D0460	Pulp vitality test					
031	D0471	Diagnostic photographs					
031	D0501	Histopathologic examinations					
031	D0502	Other oral pathology procedure					
031	D0999	Unspecified diagnostic procedure					
031	D1510	Space maintainer fxd unilat					
031	D1515	Fixed bilat space maintainer					
031	D1520	Remove unilat space maintain					
031	D1525	Remove bilat space maintain					
031	D1550	Recement space maintainer					
031	D2970	Temporary- fractured tooth					
031	D2999	Dental unspec restorative pr					
031	D3460	Endodontic endosseous implan					
031	D3999	Endodontic procedure					
031	D4250	Mucogingival surg per quadra					
031	D4260	Osseous surgery per quadrant					
031	D4263	Bone replce graft first site					
031	D4264	Bone replce graft each add					
031	D4270	Pedicle soft tissue graft pr					
031	D4271	Free soft tissue graft proc					
031	D4273	Subepithelial tissue graft					
031	D4355	Full mouth debridement					
031	D4381	Localized chemo delivery					
031	D5911	Facial moulage sectional					
031	D5912	Facial moulage complete					
031	D5983	Radiation applicator					
031	D5984	Radiation shield					
031	D5985	Radiation cone locator					
031	D5987	Commissure splint					
031	D6920	Dental connector bar					
031	D7110	Oral surgery single tooth					
031	D7120	Each add tooth extraction					
031	D7130	Tooth root removal					
031	D7210	Rem imp tooth w mucoper flp					
031	D7220	Impact tooth remov soft tiss					
031	D7230	Impact tooth remov part bony					
031	D7240	Impact tooth remov comp bony					
031	D7241	Impact tooth rem bony w/comp					
031	D7250	Tooth root removal					
031	D7260	Oral antral fistula closure					
031	D7291	Transseptal fiberotomy					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
031	D7940	Reshaping bone orthognathic					
031	D9630	Other drugs/medicaments					
031	D9930	Treatment of complications					
031	D9940	Dental occlusal guard					
031	D9950	Occlusion analysis					
031	D9951	Limited occlusal adjustment					
031	D9952	Complete occlusal adjustment					
031	K0445	Auricular prosthesis					
061	Level I Chemotherapeutic agents		X	1.04	$52.70	$36.61	$10.54
061	J8610	Methotrexate oral 2.5 MG					
061	J8999	Oral prescription drug chemo					
061	J9015	Aldesleukin/single use vial					
061	J9070	Cyclophosphamide 100 MG inj					
061	J9080	Cyclophosphamide 200 MG inj					
061	J9090	Cyclophosphamide 500 MG inj					
061	J9093	Cyclophosphamide lyophilized					
061	J9094	Cyclophosphamide lyophilized					
061	J9095	Cyclophosphamide lyophilized					
061	J9100	Cytarabine hcl 100 MG inj					
061	J9110	Cytarabine hcl 500 MG inj					
061	J9120	Dactinomycin actinomycin d					
061	J9130	Dacarbazine 10 MG inj					
061	J9140	Dacarbazine 200 MG inj					
061	J9165	Diethylstilbestrol injection					
061	J9170	Docetaxel					
061	J9181	Etoposide 10 MG inj					
061	J9190	Fluorouracil injection					
061	J9201	Gemcitabine HCl					
061	J9206	Irinotecan injection					
061	J9214	Interferon alfa-2b inj					
061	J9215	Interferon alfa-n3 inj					
061	J9218	Leuprolide acetate injection					
061	J9230	Mechlorethamine hcl inj					
061	J9250	Methotrexate sodium inj					
061	J9260	Methotrexate sodium inj					
061	J9266	Pegaspargase/singl dose vial					
061	J9350	Topotecan					
061	J9360	Vinblastine sulfate inj					
061	J9390	Vinorelbine tartrate/10 mg					
061	J9600	Porfimer sodium					
061	J9999	Chemotherapy drug					
062	Level II Chemotherapeutic agents		X	1.69	$85.63	$36.61	$17.13
062	J9000	Doxorubic hcl 10 MG vl chemo					
062	J9020	Asparaginase injection					
062	J9060	Cisplatin 10 MG injection					
062	J9065	Inj cladribine per 1 MG					
062	J9091	Cyclophosphamide 1.0 grm inj					
062	J9092	Cyclophosphamide 2.0 grm inj					
062	J9096	Cyclophosphamide lyophilized					
062	J9097	Cyclophosphamide lyophilized					
062	J9150	Daunorubicin					
062	J9211	Idarubicin hcl injection					
062	J9213	Interferon alfa-2a inj					
062	J9265	Paclitaxel injection					
062	J9268	Pentostatin injection					
062	J9370	Vincristine sulfate 1 MG inj					
063	Level III Chemotherapeutic agents		X	2.89	$146.43	$110.97	$29.29
063	J9031	Bcg live intravesical vac					
063	J9040	Bleomycin sulfate injection					
063	J9045	Carboplatin injection					
063	J9050	Carmus bischl nitro inj					
063	J9062	Cisplatin 50 MG injection					
063	J9182	Etoposide 100 MG inj					
063	J9185	Fludarabine phosphate inj					
063	J9200	Floxuridine injection					
063	J9202	Goserelin acetate implant					
063	J9208	Ifosfomide injection					
063	J9209	Mesna injection					
063	J9216	Interferon gamma 1-b inj					
063	J9270	Plicamycin (mithramycin) inj					
063	J9280	Mitomycin 5 MG inj					
063	J9320	Streptozocin injection					
063	J9340	Thiotepa injection					
063	J9375	Vincristine sulfate 2 MG inj					

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
063	J9380	Vincristine sulfate 5 MG inj					
064	Level IV Chemotherapeutic agents		X	4.17	$211.29	$140.12	$42.26
064	J0640	Leucovorin calcium injection					
064	J9217	Leuprolide acetate suspnsion					
064	J9245	Inj melphalan hydrochl 50 MG					
064	J9290	Mitomycin 20 MG inj					
064	J9291	Mitomycin 40 MG inj					
064	J9293	Mitoxantrone hydrochl / 5 MG					
089	Neuropsychological Testing		X	2.54	$128.7	$37.29	$25.74
089	96100	PSYCHOLOGICAL TESTING (INCLUDES PSYCHODIAGNOSTIC ASSESSMENT OF PERSONALITY, PSYCHOPATHOLOGY, EMOTIONALITY, INTELLECTUAL ABILITIES, EG, WAIS-R, RORSCHACH, MMPI) WITH INTERPRETATION AND REPORT, PER HOUR					
089	96105	ASSESSMENT OF APHASIA (INCLUDES ASSESSMENT OF EXPRESSIVE AND RECEPTIVE SPEECH AND LANGUAGE FUNCTION, LANGUAGE COMPREHENSION, SPEECH PRODUCTION ABILITY, READING, SPELLING, WRITING, EG, BY BOSTON DIAGNOSTIC APHASIA EXAMINATION) WITH INTERPRETATION AND REPORT					
089	96110	DEVELOPMENTAL TESTING; LIMITED (EG, DEVELOPMENTAL SCREENING TEST II, EARLY LANGUAGE MILESTONE SCREEN), WITH INTERPRETATION AND REPORT					
089	96111	DEVELOPMENTAL TESTING; EXTENDED (INCLUDES ASSESSMENT OF MOTOR, LANGUAGE, SOCIAL, ADAPTIVE AND/OR COGNITIVE FUNCTIONING BY STANDARDIZED DEVELOPMENTAL INSTRUMENTS, EG, BAYLEY SCALES OF INFANT DEVELOPMENT) WITH INTERPRETATION AND REPORT, PER HOUR					
089	96115	NEUROBEHAVIORAL STATUS EXAM (CLINICAL ASSESSMENT OF THINKING, REASONING AND JUDGMENT, EG, ACQUIRED KNOWLEDGE, ATTENTION, MEMORY, VISUAL SPATIAL ABILITIES, LANGUAGE FUNCTIONS, PLANNING) WITH INTERPRETATION AND REPORT, PER HOUR					
089	96117	NEUROPSYCHOLOGICAL TESTING BATTERY (EG, HALSTEAD-REITAN, LURIA, WAIS-R) WITH INTERPRETATION AND REPORT, PER HOUR					
090	Monitoring psychiatric drugs		X	0.85	$43.07	$12.43	$8.61
090	90862	PHARMACOLOGIC MANAGEMENT, INCLUDING PRESCRIPTION, USE, AND REVIEW OF MEDICATION WITH NO MORE THAN MINIMAL MEDICAL PSYCHOTHERAPY					
090	M0064	Visit for drug monitoring					
091	Brief Individual Psychotherapy		S	1.09	$55.23	$14.01	$11.05
091	90804	INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIENTED, BEHAVIOR MODIFYING AND/OR SUPPORTIVE, IN AN OFFICE OR OUTPATIENT FACILITY, APPROXIMATELY 20 TO 30 MINUTES FACE-TO-FACE WITH THE PATIENT;					
091	90805	INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIENTED, BEHAVIOR MODIFYING AND/OR SUPPORTIVE, IN AN OFFICE OR OUTPATIENT FACILITY, APPROXIMATELY 20 TO 30 MINUTES FACE-TO-FACE WITH THE PATIENT; WITH MEDICAL EVALUATION AND MANAGEMENT SERVICES					
091	90810	INDIVIDUAL PSYCHOTHERAPY, INTERACTIVE, USING PLAY EQUIPMENT, PHYSICAL DEVICES, LANGUAGE INTERPRETER, OR OTHER MECHANISMS OF NON-VERBAL COMMUNICATION, IN AN OFFICE OR OUTPATIENT FACILITY, APPROXIMATELY 20 TO 30 MINUTES FACE-TO-FACE WITH THE PATIENT;					
091	90811	INDIVIDUAL PSYCHOTHERAPY, INTERACTIVE, USING PLAY EQUIPMENT, PHYSICAL DEVICES, LANGUAGE INTERPRETER, OR OTHER MECHANISMS OF NON-VERBAL COMMUNICATION, IN AN OFFICE OR OUTPATIENT FACILITY, APPROXIMATELY 20 TO 30 MINUTES FACE-TO-FACE WITH THE PATIENT; WITH M					
091	90899	UNLISTED PSYCHIATRIC SERVICE OR PROCEDURE					
092	Extended Individual Psychotherapy		S	1.57	$79.55	$21.92	$15.91
092	90801	PSYCHIATRIC DIAGNOSTIC INTERVIEW EXAMINATION					
092	90802	INTERACTIVE PSYCHIATRIC DIAGNOSTIC INTERVIEW EXAMINATION USING PLAY EQUIPMENT, PHYSICAL DEVICES, LANGUAGE INTERPRETER, OR OTHER MECHANISMS OF COMMUNICATION					
092	90806	INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIENTED, BEHAVIOR MODIFYING AND/OR SUPPORTIVE, IN AN OFFICE OR OUTPATIENT FACILITY, APPROXIMATELY 45 TO 50 MINUTES FACE-TO-FACE WITH THE PATIENT;					
092	90807	INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIENTED, BEHAVIOR MODIFYING AND/OR SUPPORTIVE, IN AN OFFICE OR OUTPATIENT FACILITY, APPROXIMATELY 45 TO 50 MINUTES FACE-TO-FACE WITH THE PATIENT; WITH MEDICAL EVALUATION AND MANAGEMENT SERVICES					
092	90808	INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIENTED, BEHAVIOR MODIFYING AND/OR SUPPORTIVE, IN AN OFFICE OR OUTPATIENT FACILITY, APPROXIMATELY 75 TO 80 MINUTES FACE-TO-FACE WITH THE PATIENT;					
092	90809	INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIENTED, BEHAVIOR MODIFYING AND/OR SUPPORTIVE, IN AN OFFICE OR OUTPATIENT FACILITY, APPROXIMATELY 75 TO 80 MINUTES FACE-TO-FACE WITH THE PATIENT; WITH MEDICAL EVALUATION AND MANAGEMENT SERVICES					
092	90812	INDIVIDUAL PSYCHOTHERAPY, INTERACTIVE, USING PLAY EQUIPMENT, PHYSICAL DEVICES, LANGUAGE INTERPRETER, OR OTHER MECHANISMS OF NON-VERBAL COMMUNICATION, IN AN OFFICE OR OUTPATIENT FACILITY, APPROXIMATELY 45 TO 50 MINUTES FACE-TO-FACE WITH THE PATIENT;					
092	90813	INDIVIDUAL PSYCHOTHERAPY, INTERACTIVE, USING PLAY EQUIPMENT, PHYSICAL DEVICES, LANGUAGE INTERPRETER, OR OTHER MECHANISMS OF NON-VERBAL COMMUNICATION, IN AN OFFICE OR OUTPATIENT FACILITY, APPROXIMATELY 45 TO 50 MINUTES FACE-TO-FACE WITH THE PATIENT; WITH M					
092	90814	INDIVIDUAL PSYCHOTHERAPY, INTERACTIVE, USING PLAY EQUIPMENT, PHYSICAL DEVICES, LANGUAGE INTERPRETER, OR OTHER MECHANISMS OF NON-VERBAL COMMUNICATION, IN AN OFFICE OR OUTPATIENT FACILITY, APPROXIMATELY 75 TO 80 MINUTES FACE-TO-FACE WITH THE PATIENT;					
092	90815	INDIVIDUAL PSYCHOTHERAPY, INTERACTIVE, USING PLAY EQUIPMENT, PHYSICAL DEVICES, LANGUAGE INTERPRETER, OR OTHER MECHANISMS OF NON-VERBAL COMMUNICATION, IN AN OFFICE OR OUTPATIENT FACILITY, APPROXIMATELY 75 TO 80 MINUTES FACE-TO-FACE WITH THE PATIENT; WITH M					
092	90845	PSYCHOANALYSIS					
092	90865	NARCOSYNTHESIS FOR PSYCHIATRIC DIAGNOSTIC AND THERAPEUTIC PURPOSES (EG, SODIUM AMOBARBITAL (AMYTAL) INTERVIEW					
092	90880	HYPNOTHERAPY					
093	Family Psychotherapy		S	1.54	$78.03	$20.11	$15.61

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
093	90846	FAMILY PSYCHOTHERAPY (WITHOUT THE PATIENT PRESENT)					
093	90847	FAMILY PSYCHOTHERAPY (CONJOINT PSYCHOTHERAPY) (WITH PATIENT PRESENT)					
094	Group Psychotherapy		S	1.24	$62.83	$20.11	$12.57
094	90849	MULTIPLE-FAMILY GROUP PSYCHOTHERAPY					
094	90853	GROUP PSYCHOTHERAPY (OTHER THAN OF A MULTIPLE-FAMILY GROUP)					
094	90857	INTERACTIVE GROUP PSYCHOTHERAPY					
121	Level I needle biopsy/aspiration		T	0.67	$33.95	$20.91	$6.79
121	17999	UNLISTED PROCEDURE, SKIN, MUCOUS MEMBRANE AND SUBCUTANEOUS TISSUE					
121	19000	PUNCTURE ASPIRATION OF CYST OF BREAST;					
121	19001	PUNCTURE ASPIRATION OF CYST OF BREAST; EACH ADDITIONAL CYST					
121	20615	ASPIRATION AND INJECTION FOR TREATMENT OF BONE CYST					
121	55000	PUNCTURE ASPIRATION OF HYDROCELE, TUNICA VAGINALIS, WITH OR WITHOUT INJECTION OF MEDICATION					
121	60001	ASPIRATION AND/OR INJECTION, THYROID CYST					
121	60699	UNLISTED PROCEDURE, ENDOCRINE SYSTEM					
121	85095	BONE MARROW; ASPIRATION ONLY					
121	85102	BONE MARROW BIOPSY, NEEDLE OR TROCAR					
121	88170	FINE NEEDLE ASPIRATION WITH OR WITHOUT PREPARATION OF SMEARS; SUPERFICIAL TISSUE (EG, THYROID, BREAST, PROSTATE					
121	88171	FINE NEEDLE ASPIRATION WITH OR WITHOUT PREPARATION OF SMEARS; DEEP TISSUE UNDER RADIOLOGIC GUIDANCE					
122	Level II needle biopsy/aspiration		T	4.87	$246.76	$115.03	$49.35
122	19100	BIOPSY OF BREAST; NEEDLE CORE (SEPARATE PROCEDURE)					
122	20206	BIOPSY, MUSCLE, PERCUTANEOUS NEEDLE					
122	32400	BIOPSY, PLEURA; PERCUTANEOUS NEEDLE					
122	32405	BIOPSY, LUNG OR MEDIASTINUM, PERCUTANEOUS NEEDLE					
122	38505	BIOPSY OR EXCISION OF LYMPH NODE(S); BY NEEDLE, SUPERFICIAL (EG, CERVICAL, INGUINAL, AXILLARY)					
122	42400	BIOPSY OF SALIVARY GLAND; NEEDLE					
122	47000	BIOPSY OF LIVER, NEEDLE; PERCUTANEOUS					
122	47399	UNLISTED PROCEDURE, LIVER					
122	48102	BIOPSY OF PANCREAS, PERCUTANEOUS NEEDLE					
122	48999	UNLISTED PROCEDURE, PANCREAS					
122	49180	BIOPSY, ABDOMINAL OR RETROPERITONEAL MASS, PERCUTANEOUS NEEDLE					
122	50200	RENAL BIOPSY; PERCUTANEOUS, BY TROCAR OR NEEDLE					
122	50390	ASPIRATION AND/OR INJECTION OF RENAL CYST OR PELVIS BY NEEDLE, PERCUTANEOUS					
122	54500	BIOPSY OF TESTIS, NEEDLE (SEPARATE PROCEDURE)					
122	54800	BIOPSY OF EPIDIDYMIS, NEEDLE					
122	60100	BIOPSY THYROID, PERCUTANEOUS CORE NEEDLE					
122	62269	BIOPSY OF SPINAL CORD, PERCUTANEOUS NEEDLE					
122	67415	FINE NEEDLE ASPIRATION OF ORBITAL CONTENTS					
131	Level I incision & drainage		T	1.94	$98.30	$36.61	$19.66
131	10040	ACNE SURGERY (EG, MARSUPIALIZATION, OPENING OR REMOVAL OF MULTIPLE MILIA, COMEDONES, CYSTS, PUSTULES)					
131	10060	INCISION AND DRAINAGE OF ABSCESS (EG, CARBUNCLE, SUPPURATIVE HIDRADENITIS, CUTANEOUS OR SUBCUTANEOUS ABSCESS, CYST, FURUNCLE, OR PARONYCHIA); SIMPLE OR SINGLE					
131	10061	INCISION AND DRAINAGE OF ABSCESS (EG, CARBUNCLE, SUPPURATIVE HIDRADENITIS, CUTANEOUS OR SUBCUTANEOUS ABSCESS, CYST, FURUNCLE, OR PARONYCHIA); COMPLICATED OR MULTIPLE					
131	10080	INCISION AND DRAINAGE OF PILONIDAL CYST; SIMPLE					
131	10081	INCISION AND DRAINAGE OF PILONIDAL CYST; COMPLICATED					
131	10120	INCISION AND REMOVAL OF FOREIGN BODY, SUBCUTANEOUS TISSUES; SIMPLE					
131	10140	INCISION AND DRAINAGE OF HEMATOMA, SEROMA OR FLUID COLLECTION					
131	10160	PUNCTURE ASPIRATION OF ABSCESS, HEMATOMA, BULLA, OR CYST					
131	10180	INCISION AND DRAINAGE, COMPLEX, POSTOPERATIVE WOUND INFECTION					
131	11976	REMOVAL, IMPLANTABLE CONTRACEPTIVE CAPSULES					
131	20000	INCISION OF SOFT TISSUE ABSCESS (EG, SECONDARY TO OSTEOMYELITIS); SUPERFICIAL					
131	26010	DRAINAGE OF FINGER ABSCESS; SIMPLE					
131	26011	DRAINAGE OF FINGER ABSCESS; COMPLICATED (EG, FELON)					
131	69000	DRAINAGE EXTERNAL EAR, ABSCESS OR HEMATOMA; SIMPLE					
131	69005	DRAINAGE EXTERNAL EAR, ABSCESS OR HEMATOMA; COMPLICATED					
131	69020	DRAINAGE EXTERNAL AUDITORY CANAL, ABSCESS					
132	Level II incision & drainage		T	6.04	$306.04	$134.13	$61.21
132	19020	MASTOTOMY WITH EXPLORATION OR DRAINAGE OF ABSCESS, DEEP					
132	20950	MONITORING OF INTERSTITIAL FLUID PRESSURE (INCLUDES INSERTION OF DEVICE, EG, WICK CATHETER TECHNIQUE, NEEDLE MANOMETER TECHNIQUE) IN DETECTION OF MUSCLE COMPARTMENT SYNDROME					
132	21501	INCISION AND DRAINAGE, DEEP ABSCESS OR HEMATOMA, SOFT TISSUES OF NECK OR THORAX;					
132	21700	DIVISION OF SCALENUS ANTICUS; WITHOUT RESECTION OF CERVICAL RIB					
132	21720	DIVISION OF STERNOCLEIDOMASTOID FOR TORTICOLLIS, OPEN OPERATION; WITHOUT CAST APPLICATION					
132	21725	DIVISION OF STERNOCLEIDOMASTOID FOR TORTICOLLIS, OPEN OPERATION; WITH CAST APPLICATION					
132	23030	INCISION AND DRAINAGE, SHOULDER AREA; DEEP ABSCESS OR HEMATOMA					
132	23031	INCISION AND DRAINAGE, SHOULDER AREA; INFECTED BURSA					
132	23930	INCISION AND DRAINAGE, UPPER ARM OR ELBOW AREA; DEEP ABSCESS OR HEMATOMA					
132	23931	INCISION AND DRAINAGE, UPPER ARM OR ELBOW AREA; INFECTED BURSA					
132	27301	INCISION AND DRAINAGE OF DEEP ABSCESS, INFECTED BURSA, OR HEMATOMA, THIGH OR KNEE REGION					
132	27603	INCISION AND DRAINAGE, LEG OR ANKLE; DEEP ABSCESS OR HEMATOMA					
132	28001	INCISION AND DRAINAGE, INFECTED BURSA, FOOT					
132	38300	DRAINAGE OF LYMPH NODE ABSCESS OR LYMPHADENITIS; SIMPLE					

(See Addendum D. for Payment of Medical Visits)

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
132	38305	DRAINAGE OF LYMPH NODE ABSCESS OR LYMPHADENITIS; EXTENSIVE					
132	38999	UNLISTED PROCEDURE, HEMIC OR LYMPHATIC SYSTEM					
132	51080	DRAINAGE OF PERIVESICAL OR PREVESICAL SPACE ABSCESS					
132	54015	INCISION AND DRAINAGE OF PENIS, DEEP					
132	54115	REMOVAL FOREIGN BODY FROM DEEP PENILE TISSUE (EG, PLASTIC IMPLANT)					
132	55100	DRAINAGE OF SCROTAL WALL ABSCESS					
137	Nail procedures		T	0.46	$23.31	$4.66	$4.66
137	11719	TRIMMING OF NONDYSTROPHIC NAILS, ANY NUMBER					
137	11720	DEBRIDEMENT OF NAIL(S) BY ANY METHOD(S); ONE TO FIVE					
137	11721	DEBRIDEMENT OF NAIL(S) BY ANY METHOD(S); SIX OR MORE					
137	11740	EVACUATION OF SUBUNGUAL HEMATOMA					
137	11755	BIOPSY OF NAIL UNIT, ANY METHOD (EG, PLATE, BED, MATRIX, HYPONYCHIUM, PROXIMAL AND LATERAL NAIL FOLDS) (SEPARATE PROCEDURE)					
141	Level I Destruction of lesion		T	0.59	$29.90	$9.49	$5.98
141	17000	DESTRUCTION BY ANY METHOD, INCLUDING LASER, WITH OR WITHOUT SURGICAL CURETTEMENT, ALL BENIGN OR PREMALIGNANT LESIONS (EG, ACTINIC KERATOSES) OTHER THAN SKIN TAGS OR CUTANEOUS VASCULAR PROLIFERATIVE LESIONS, INCLUDING LOCAL ANESTHESIA; FIRST LESION					
141	17003	DESTRUCTION BY ANY METHOD, INCLUDING LASER, WITH OR WITHOUT SURGICAL CURETTEMENT, ALL BENIGN OR PREMALIGNANT LESIONS (EG, ACTINIC KERATOSES) OTHER THAN SKIN TAGS OR CUTANEOUS VASCULAR PROLIFERATIVE LESIONS, INCLUDING LOCAL ANESTHESIA; SECOND THROUGH 14 LE					
141	17106	DESTRUCTION OF CUTANEOUS VASCULAR PROLIFERATIVE LESIONS (EG, LASER TECHNIQUE); LESS THAN 10 SQ CM					
141	17110	DESTRUCTION BY ANY METHOD OF FLAT WARTS, MOLLUSCUM CONTAGIOSUM, OR MILIA; UP TO 14 LESIONS					
142	Level II Destruction of lesion		T	3.77	$191.02	$73.00	$38.20
142	17004	DESTRUCTION BY ANY METHOD, INCLUDING LASER, WITH OR WITHOUT SURGICAL CURETTEMENT, ALL BENIGN OR PREMALIGNANT LESIONS (EG, ACTINIC KERATOSES) OTHER THAN SKIN TAGS OR CUTANEOUS VASCULAR PROLIFERATIVE LESIONS, INCLUDING LOCAL ANESTHESIA; 15 OR MORE LESIONS					
142	17107	DESTRUCTION OF CUTANEOUS VASCULAR PROLIFERATIVE LESIONS (EG, LASER TECHNIQUE); 10.0–50.0 SQ CM					
142	17108	DESTRUCTION OF CUTANEOUS VASCULAR PROLIFERATIVE LESIONS (EG, LASER TECHNIQUE); OVER 50.0 SQ CM					
142	17111	DESTRUCTION BY ANY METHOD OF FLAT WARTS, MOLLUSCUM CONTAGIOSUM, OR MILIA; 15 OR MORE LESIONS					
151	Level I debridement/destruction		T	1.74	$88.16	$35.71	$17.63
151	11000	DEBRIDEMENT OF EXTENSIVE ECZEMATOUS OR INFECTED SKIN; UP TO 10% OF BODY SURFACE					
151	11001	DEBRIDEMENT OF EXTENSIVE ECZEMATOUS OR INFECTED SKIN; EACH ADDITIONAL 10% OF THE BODY SURFACE					
151	11040	DEBRIDEMENT; SKIN, PARTIAL THICKNESS					
151	11041	DEBRIDEMENT; SKIN, FULL THICKNESS					
151	11042	DEBRIDEMENT; SKIN, AND SUBCUTANEOUS TISSUE					
151	11055	PARING OR CUTTING OF BENIGN HYPERKERATOTIC LESION (EG, CORN OR CALLUS); SINGLE LESION					
151	11056	PARING OR CUTTING OF BENIGN HYPERKERATOTIC LESION (EG, CORN OR CALLUS); TWO TO FOUR LESIONS					
151	11057	PARING OR CUTTING OF BENIGN HYPERKERATOTIC LESION (EG, CORN OR CALLUS); MORE THAN FOUR LESIONS					
151	11200	REMOVAL OF SKIN TAGS, MULTIPLE FIBROCUTANEOUS TAGS, ANY AREA; UP TO AND INCLUDING 15 LESIONS					
151	11201	REMOVAL OF SKIN TAGS, MULTIPLE FIBROCUTANEOUS TAGS, ANY AREA; EACH ADDITIONAL TEN LESIONS					
151	11300	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, TRUNK, ARMS OR LEGS; LESION DIAMETER 0.5 CM OR LESS					
151	11301	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, TRUNK, ARMS OR LEGS; LESION DIAMETER 0.6 TO 1.0 CM					
151	11302	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, TRUNK, ARMS OR LEGS; LESION DIAMETER 1.1 TO 2.0 CM					
151	11303	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, TRUNK, ARMS OR LEGS; LESION DIAMETER OVER 2.0 CM					
151	11305	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER 0.5 CM OR LESS					
151	11306	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER 0.6 TO 1.0 CM					
151	11307	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER 1.1 TO 2.0 CM					
151	11308	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER OVER 2.0 CM					
151	11310	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; LESION DIAMETER 0.5 CM OR LESS					
151	11311	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; LESION DIAMETER 0.6 TO 1.0 CM					
151	11312	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; LESION DIAMETER 1.1 TO 2.0 CM					
151	11313	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; LESION DIAMETER OVER 2.0 CM					
151	11730	AVULSION OF NAIL PLATE, PARTIAL OR COMPLETE, SIMPLE; SINGLE					
151	11731	AVULSION OF NAIL PLATE, PARTIAL OR COMPLETE, SIMPLE; SECOND NAIL PLATE					
151	11732	AVULSION OF NAIL PLATE, PARTIAL OR COMPLETE, SIMPLE; EACH ADDITIONAL NAIL PLATE					
151	11765	WEDGE EXCISION OF SKIN OF NAIL FOLD (EG, FOR INGROWN TOENAIL)					
151	11900	INJECTION, INTRALESIONAL; UP TO AND INCLUDING SEVEN LESIONS					
151	11901	INJECTION, INTRALESIONAL; MORE THAN SEVEN LESIONS					
151	15783	DERMABRASION; SUPERFICIAL, ANY SITE, (EG, TATTOO REMOVAL)					
151	15786	ABRASION; SINGLE LESION (EG, KERATOSIS, SCAR)					
151	15787	ABRASION; EACH ADDITIONAL FOUR LESIONS OR LESS					
151	15788	CHEMICAL PEEL, FACIAL; EPIDERMAL					
151	15789	CHEMICAL PEEL, FACIAL; DERMAL					
151	15792	CHEMICAL PEEL, NONFACIAL; EPIDERMAL					
151	15793	CHEMICAL PEEL, NONFACIAL; DERMAL					

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
151	15810	SALABRASION; 20 SQ CM OR LESS					
151	15850	REMOVAL OF SUTURES UNDER ANESTHESIA (OTHER THAN LOCAL), SAME SURGEON					
151	15851	REMOVAL OF SUTURES UNDER ANESTHESIA (OTHER THAN LOCAL), OTHER SURGEON					
151	15852	DRESSING CHANGE (FOR OTHER THAN BURNS) UNDER ANESTHESIA (OTHER THAN LOCAL)					
151	16000	INITIAL TREATMENT, FIRST DEGREE BURN, WHEN NO MORE THAN LOCAL TREATMENT IS REQUIRED					
151	16020	DRESSINGS AND/OR DEBRIDEMENT, INITIAL OR SUBSEQUENT; WITHOUT ANESTHESIA, OFFICE OR HOSPITAL, SMALL					
151	16025	DRESSINGS AND/OR DEBRIDEMENT, INITIAL OR SUBSEQUENT; WITHOUT ANESTHESIA, MEDIUM (EG, WHOLE FACE OR WHOLE EXTREMITY)					
151	16030	DRESSINGS AND/OR DEBRIDEMENT, INITIAL OR SUBSEQUENT; WITHOUT ANESTHESIA, LARGE (EG, MORE THAN ONE EXTREMITY)					
151	17250	CHEMICAL CAUTERIZATION OF GRANULATION TISSUE (PROUD FLESH, SINUS OR FISTULA)					
151	17260	DESTRUCTION, MALIGNANT LESION, ANY METHOD, TRUNK, ARMS OR LEGS; LESION DIAMETER 0.5 CM OR LESS					
151	17261	DESTRUCTION, MALIGNANT LESION, ANY METHOD, TRUNK, ARMS OR LEGS; LESION DIAMETER 0.6 TO 1.0 CM					
151	17262	DESTRUCTION, MALIGNANT LESION, ANY METHOD, TRUNK, ARMS OR LEGS; LESION DIAMETER 1.1 TO 2.0 CM					
151	17263	DESTRUCTION, MALIGNANT LESION, ANY METHOD, TRUNK, ARMS OR LEGS; LESION DIAMETER 2.1 TO 3.0 CM					
151	17264	DESTRUCTION, MALIGNANT LESION, ANY METHOD, TRUNK, ARMS OR LEGS; LESION DIAMETER 3.1 TO 4.0 CM					
151	17266	DESTRUCTION, MALIGNANT LESION, ANY METHOD, TRUNK, ARMS OR LEGS; LESION DIAMETER OVER 4.0 CM					
151	17270	DESTRUCTION, MALIGNANT LESION, ANY METHOD, SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER 0.5 CM OR LESS					
151	17271	DESTRUCTION, MALIGNANT LESION, ANY METHOD, SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER 0.6 TO 1.0 CM					
151	17272	DESTRUCTION, MALIGNANT LESION, ANY METHOD, SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER 1.1 TO 2.0 CM					
151	17273	DESTRUCTION, MALIGNANT LESION, ANY METHOD, SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER 2.1 TO 3.0 CM					
151	17274	DESTRUCTION, MALIGNANT LESION, ANY METHOD, SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER 3.1 TO 4.0 CM					
151	17276	DESTRUCTION, MALIGNANT LESION, ANY METHOD, SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER OVER 4.0 CM					
151	17280	DESTRUCTION, MALIGNANT LESION, ANY METHOD, FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; LESION DIAMETER 0.5 CM OR LESS					
151	17281	DESTRUCTION, MALIGNANT LESION, ANY METHOD, FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; LESION DIAMETER 0.6 TO 1.0 CM					
151	17282	DESTRUCTION, MALIGNANT LESION, ANY METHOD, FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; LESION DIAMETER 1.1 TO 2.0 CM					
151	17283	DESTRUCTION, MALIGNANT LESION, ANY METHOD, FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; LESION DIAMETER 2.1 TO 3.0 CM					
151	17284	DESTRUCTION, MALIGNANT LESION, ANY METHOD, FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; LESION DIAMETER 3.1 TO 4.0 CM					
151	17286	DESTRUCTION, MALIGNANT LESION, ANY METHOD, FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; LESION DIAMETER OVER 4.0 CM					
151	17340	CRYOTHERAPY (CO2 SLUSH, LIQUID N2) FOR ACNE					
151	17360	CHEMICAL EXFOLIATION FOR ACNE (EG, ACNE PASTE, ACID)					
151	17380	ELECTROLYSIS EPILATION, EACH 1/2 HOUR					
151	42809	REMOVAL OF FOREIGN BODY FROM PHARYNX					
151	69220	DEBRIDEMENT, MASTOIDECTOMY CAVITY, SIMPLE (EG, ROUTINE CLEANING)					
152	Level II debridement/destruction		T	10.43	$528.48	$261.71	$105.7
152	16010	DRESSINGS AND/OR DEBRIDEMENT, INITIAL OR SUBSEQUENT; UNDER ANESTHESIA, SMALL					
152	16015	DRESSINGS AND/OR DEBRIDEMENT, INITIAL OR SUBSEQUENT; UNDER ANESTHESIA, MEDIUM OR LARGE, OR WITH MAJOR DEBRIDEMENT					
152	46900	DESTRUCTION OF LESION(S), ANUS (EG, CONDYLOMA, PAPILLOMA, MOLLUSCUM CONTAGIOSUM, HERPETIC VESICLE), SIMPLE; CHEMICAL					
152	46910	DESTRUCTION OF LESION(S), ANUS (EG, CONDYLOMA, PAPILLOMA, MOLLUSCUM CONTAGIOSUM, HERPETIC VESICLE), SIMPLE; ELECTRODESICCATION					
152	46916	DESTRUCTION OF LESION(S), ANUS (EG, CONDYLOMA, PAPILLOMA, MOLLUSCUM CONTAGIOSUM, HERPETIC VESICLE), SIMPLE; CRYOSURGERY					
152	46917	DESTRUCTION OF LESION(S), ANUS (EG, CONDYLOMA, PAPILLOMA, MOLLUSCUM CONTAGIOSUM, HERPETIC VESICLE), SIMPLE; LASER SURGERY					
152	46922	DESTRUCTION OF LESION(S), ANUS (EG, CONDYLOMA, PAPILLOMA, MOLLUSCUM CONTAGIOSUM, HERPETIC VESICLE), SIMPLE; SURGICAL EXCISION					
152	46924	DESTRUCTION OF LESION(S), ANUS (EG, CONDYLOMA, PAPILLOMA, MOLLUSCUM CONTAGIOSUM, HERPETIC VESICLE), EXTENSIVE, ANY METHOD					
152	54050	DESTRUCTION OF LESION(S), PENIS (EG, CONDYLOMA, PAPILLOMA, MOLLUSCUM CONTAGIOSUM, HERPETIC VESICLE), SIMPLE; CHEMICAL					
152	54055	DESTRUCTION OF LESION(S), PENIS (EG, CONDYLOMA, PAPILLOMA, MOLLUSCUM CONTAGIOSUM, HERPETIC VESICLE), SIMPLE; ELECTRODESICCATION					
152	54056	DESTRUCTION OF LESION(S), PENIS (EG, CONDYLOMA, PAPILLOMA, MOLLUSCUM CONTAGIOSUM, HERPETIC VESICLE), SIMPLE; CRYOSURGERY					
152	54057	DESTRUCTION OF LESION(S), PENIS (EG, CONDYLOMA, PAPILLOMA, MOLLUSCUM CONTAGIOSUM, HERPETIC VESICLE), SIMPLE; LASER SURGERY					
152	54060	DESTRUCTION OF LESION(S), PENIS (EG, CONDYLOMA, PAPILLOMA, MOLLUSCUM CONTAGIOSUM, HERPETIC VESICLE), SIMPLE; SURGICAL EXCISION					
152	54065	DESTRUCTION OF LESION(S), PENIS (EG, CONDYLOMA, PAPILLOMA, MOLLUSCUM CONTAGIOSUM, HERPETIC VESICLE), EXTENSIVE, ANY METHOD					
152	56501	DESTRUCTION OF LESION(S), VULVA; SIMPLE, ANY METHOD					
152	56515	DESTRUCTION OF LESION(S), VULVA; EXTENSIVE, ANY METHOD					
161	Level I excision/biopsy		T	3.50	$177.34	$75.48	$35.47
161	11100	BIOPSY OF SKIN, SUBCUTANEOUS TISSUE AND/OR MUCOUS MEMBRANE (INCLUDING SIMPLE CLOSURE), UNLESS OTHERWISE LISTED (SEPARATE PROCEDURE); SINGLE LESION					
161	11101	BIOPSY OF SKIN, SUBCUTANEOUS TISSUE AND/OR MUCOUS MEMBRANE (INCLUDING SIMPLE CLOSURE), UNLESS OTHERWISE LISTED (SEPARATE PROCEDURE); EACH SEPARATE/ADDITIONAL LESION					

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
161	11400	EXCISION, BENIGN LESION, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), TRUNK, ARMS OR LEGS; LESION DIAMETER 0.5 CM OR LESS					
161	11401	EXCISION, BENIGN LESION, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), TRUNK, ARMS OR LEGS; LESION DIAMETER 0.6 TO 1.0 CM					
161	11402	EXCISION, BENIGN LESION, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), TRUNK, ARMS OR LEGS; LESION DIAMETER 1.1 TO 2.0 CM					
161	11403	EXCISION, BENIGN LESION, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), TRUNK, ARMS OR LEGS; LESION DIAMETER 2.1 TO 3.0 CM					
161	11420	EXCISION, BENIGN LESION, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER 0.5 CM OR LESS					
161	11421	EXCISION, BENIGN LESION, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER 0.6 TO 1.0 CM					
161	11422	EXCISION, BENIGN LESION, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER 1.1 TO 2.0 CM					
161	11423	EXCISION, BENIGN LESION, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER 2.1 TO 3.0 CM					
161	11440	EXCISION, OTHER BENIGN LESION (UNLESS LISTED ELSEWHERE), FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; LESION DIAMETER 0.5 CM OR LESS					
161	11441	EXCISION, OTHER BENIGN LESION (UNLESS LISTED ELSEWHERE), FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; LESION DIAMETER 0.6 TO 1.0 CM					
161	11442	EXCISION, OTHER BENIGN LESION (UNLESS LISTED ELSEWHERE), FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; LESION DIAMETER 1.1 TO 2.0 CM					
161	11443	EXCISION, OTHER BENIGN LESION (UNLESS LISTED ELSEWHERE), FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; LESION DIAMETER 2.1 TO 3.0 CM					
161	11600	EXCISION, MALIGNANT LESION, TRUNK, ARMS, OR LEGS; LESION DIAMETER 0.5 CM OR LESS					
161	11601	EXCISION, MALIGNANT LESION, TRUNK, ARMS, OR LEGS; LESION DIAMETER 0.6 TO 1.0 CM					
161	11602	EXCISION, MALIGNANT LESION, TRUNK, ARMS, OR LEGS; LESION DIAMETER 1.1 TO 2.0 CM					
161	11603	EXCISION, MALIGNANT LESION, TRUNK, ARMS, OR LEGS; LESION DIAMETER 2.1 TO 3.0 CM					
161	11620	EXCISION, MALIGNANT LESION, SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER 0.5 CM OR LESS					
161	11621	EXCISION, MALIGNANT LESION, SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER 0.6 TO 1.0 CM					
161	11622	EXCISION, MALIGNANT LESION, SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER 1.1 TO 2.0 CM					
161	11623	EXCISION, MALIGNANT LESION, SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER 2.1 TO 3.0 CM					
161	11640	EXCISION, MALIGNANT LESION, FACE, EARS, EYELIDS, NOSE, LIPS; LESION DIAMETER 0.5 CM OR LESS					
161	11641	EXCISION, MALIGNANT LESION, FACE, EARS, EYELIDS, NOSE, LIPS; LESION DIAMETER 0.6 TO 1.0 CM					
161	11642	EXCISION, MALIGNANT LESION, FACE, EARS, EYELIDS, NOSE, LIPS; LESION DIAMETER 1.1 TO 2.0 CM					
161	11643	EXCISION, MALIGNANT LESION, FACE, EARS, EYELIDS, NOSE, LIPS; LESION DIAMETER 2.1 TO 3.0 CM					
161	11750	EXCISION OF NAIL AND NAIL MATRIX, PARTIAL OR COMPLETE, (EG, INGROWN OR DEFORMED NAIL) FOR PERMANENT REMOVAL;					
161	20520	REMOVAL OF FOREIGN BODY IN MUSCLE OR TENDON SHEATH; SIMPLE					
161	21550	BIOPSY, SOFT TISSUE OF NECK OR THORAX					
161	21920	BIOPSY, SOFT TISSUE OF BACK OR FLANK; SUPERFICIAL					
161	23065	BIOPSY, SOFT TISSUE OF SHOULDER AREA; SUPERFICIAL					
161	24065	BIOPSY, SOFT TISSUE OF UPPER ARM OR ELBOW AREA; SUPERFICIAL					
161	24200	REMOVAL OF FOREIGN BODY, UPPER ARM OR ELBOW AREA; SUBCUTANEOUS					
161	25065	BIOPSY, SOFT TISSUE OF FOREARM AND/OR WRIST; SUPERFICIAL					
161	27613	BIOPSY, SOFT TISSUE OF LEG OR ANKLE AREA; SUPERFICIAL					
161	28190	REMOVAL OF FOREIGN BODY, FOOT; SUBCUTANEOUS					
161	56605	BIOPSY OF VULVA OR PERINEUM (SEPARATE PROCEDURE); ONE LESION					
161	56606	BIOPSY OF VULVA OR PERINEUM (SEPARATE PROCEDURE); EACH SEPARATE ADDITIONAL LESION					
161	58999	UNLISTED PROCEDURE, FEMALE GENITAL SYSTEM (NONOBSTETRICAL)					
161	69100	BIOPSY EXTERNAL EAR					
161	69105	BIOPSY EXTERNAL AUDITORY CANAL					
162	Level II excision/biopsy		T	5.67	$287.30	$125.43	$57.46
162	11043	DEBRIDEMENT; SKIN, SUBCUTANEOUS TISSUE, AND MUSCLE					
162	11044	DEBRIDEMENT; SKIN, SUBCUTANEOUS TISSUE, MUSCLE, AND BONE					
162	11404	EXCISION, BENIGN LESION, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), TRUNK, ARMS OR LEGS; LESION DIAMETER 3.1 TO 4.0 CM					
162	11424	EXCISION, BENIGN LESION, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER 3.1 TO 4.0 CM					
162	11444	EXCISION, OTHER BENIGN LESION (UNLESS LISTED ELSEWHERE), FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; LESION DIAMETER 3.1 TO 4.0 CM					
162	11604	EXCISION, MALIGNANT LESION, TRUNK, ARMS, OR LEGS; LESION DIAMETER 3.1 TO 4.0 CM					
162	11770	EXCISION OF PILONIDAL CYST OR SINUS; SIMPLE					
162	16035	ESCHAROTOMY					
162	16040	EXCISION BURN WOUND, WITHOUT SKIN GRAFTING, EMPLOYING ALLOPLASTIC DRESSING (EG, SYNTHETIC MESH), ANY ANATOMIC SITE; UP TO ONE PERCENT TOTAL BODY SURFACE AREA					
162	16041	EXCISION BURN WOUND, WITHOUT SKIN GRAFTING, EMPLOYING ALLOPLASTIC DRESSING (EG, SYNTHETIC MESH), ANY ANATOMIC SITE; GREATER THAN ONE PERCENT AND UP TO NINE PERCENT TOTAL BODY SURFACE AREA					
162	16042	EXCISION BURN WOUND, WITHOUT SKIN GRAFTING, EMPLOYING ALLOPLASTIC DRESSING (EG, SYNTHETIC MESH), ANY ANATOMIC SITE; EACH ADDITIONAL NINE PERCENT TOTAL BODY SURFACE AREA, OR PART THEREOF					
162	17304	CHEMOSURGERY (MOHS' MICROGRAPHIC TECHNIQUE), INCLUDING REMOVAL OF ALL GROSS TUMOR, SURGICAL EXCISION OF TISSUE SPECIMENS, MAPPING, COLOR CODING OF SPECIMENS, MICROSCOPIC EXAMINATION OF SPECIMENS BY THE SURGEON, AND COMPLETE HISTOPATHOLOGIC PREPARATION; FI					
162	17305	CHEMOSURGERY (MOHS' MICROGRAPHIC TECHNIQUE), INCLUDING REMOVAL OF ALL GROSS TUMOR, SURGICAL EXCISION OF TISSUE SPECIMENS, MAPPING, COLOR CODING OF SPECIMENS, MICROSCOPIC EXAMINATION OF SPECIMENS BY THE SURGEON, AND COMPLETE HISTOPATHOLOGIC PREPARATION; SE					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
162	17306	CHEMOSURGERY (MOHS' MICROGRAPHIC TECHNIQUE), INCLUDING REMOVAL OF ALL GROSS TUMOR, SURGICAL EXCISION OF TISSUE SPECIMENS, MAPPING, COLOR CODING OF SPECIMENS, MICROSCOPIC EXAMINATION OF SPECIMENS BY THE SURGEON, AND COMPLETE HISTOPATHOLOGIC PREPARATION; TH					
162	17307	CHEMOSURGERY (MOHS' MICROGRAPHIC TECHNIQUE), INCLUDING REMOVAL OF ALL GROSS TUMOR, SURGICAL EXCISION OF TISSUE SPECIMENS, MAPPING, COLOR CODING OF SPECIMENS, MICROSCOPIC EXAMINATION OF SPECIMENS BY THE SURGEON, AND COMPLETE HISTOPATHOLOGIC PREPARATION; AD					
162	17310	CHEMOSURGERY (MOHS' MICROGRAPHIC TECHNIQUE), INCLUDING REMOVAL OF ALL GROSS TUMOR, SURGICAL EXCISION OF TISSUE SPECIMENS, MAPPING, COLOR CODING OF SPECIMENS, MICROSCOPIC EXAMINATION OF SPECIMENS BY THE SURGEON, AND COMPLETE HISTOPATHOLOGIC PREPARATION; MO					
162	20200	BIOPSY, MUSCLE; SUPERFICIAL					
162	20205	BIOPSY, MUSCLE; DEEP					
162	20220	BIOPSY, BONE, TROCAR, OR NEEDLE; SUPERFICIAL (EG, ILIUM, STERNUM, SPINOUS PROCESS, RIBS)					
162	20225	BIOPSY, BONE, TROCAR, OR NEEDLE; DEEP (VERTEBRAL BODY, FEMUR)					
162	20670	REMOVAL OF IMPLANT; SUPERFICIAL, (EG, BURIED WIRE, PIN OR ROD) (SEPARATE PROCEDURE)					
162	23000	REMOVAL OF SUBDELTOID (OR INTRATENDINOUS) CALCAREOUS DEPOSITS, OPEN METHOD					
162	23075	EXCISION, TUMOR, SHOULDER AREA; SUBCUTANEOUS					
162	24075	EXCISION, TUMOR, UPPER ARM OR ELBOW AREA; SUBCUTANEOUS					
162	25075	EXCISION, TUMOR, FOREARM AND/OR WRIST AREA; SUBCUTANEOUS					
162	27040	BIOPSY, SOFT TISSUE OF PELVIS AND HIP AREA; SUPERFICIAL					
162	27323	BIOPSY, SOFT TISSUE OF THIGH OR KNEE AREA; SUPERFICIAL					
162	28043	EXCISION, TUMOR, FOOT; SUBCUTANEOUS					
162	37609	LIGATION OR BIOPSY, TEMPORAL ARTERY					
162	37799	UNLISTED PROCEDURE, VASCULAR SURGERY					
162	54100	BIOPSY OF PENIS; CUTANEOUS (SEPARATE PROCEDURE)					
162	54105	BIOPSY OF PENIS; DEEP STRUCTURES					
162	67350	BIOPSY OF EXTRAOCULAR MUSCLE					
162	67399	UNLISTED PROCEDURE, OCULAR MUSCLE					
162	68100	BIOPSY OF CONJUNCTIVA					
162	68110	EXCISION OF LESION, CONJUNCTIVA; UP TO 1 CM					
162	68115	EXCISION OF LESION, CONJUNCTIVA; OVER 1 CM					
162	68135	DESTRUCTION OF LESION, CONJUNCTIVA					
162	68399	UNLISTED PROCEDURE, CONJUNCTIVA					
163	Level III excision/biopsy		T	10.69	$541.66	$264.65	$108.33
163	10121	INCISION AND REMOVAL OF FOREIGN BODY, SUBCUTANEOUS TISSUES; COMPLICATED					
163	11010	DEBRIDEMENT INCLUDING REMOVAL OF FOREIGN MATERIAL ASSOCIATED WITH OPEN FRACTURE(S) AND/OR DISLOCATION(S); SKIN AND SUBCUTANEOUS TISSUES					
163	11011	DEBRIDEMENT INCLUDING REMOVAL OF FOREIGN MATERIAL ASSOCIATED WITH OPEN FRACTURE(S) AND/OR DISLOCATION(S); SKIN, SUBCUTANEOUS TISSUE, MUSCLE FASCIA, AND MUSCLE					
163	11012	DEBRIDEMENT INCLUDING REMOVAL OF FOREIGN MATERIAL ASSOCIATED WITH OPEN FRACTURE(S) AND/OR DISLOCATION(S); SKIN, SUBCUTANEOUS TISSUE, MUSCLE FASCIA, MUSCLE, AND BONE					
163	11406	EXCISION, BENIGN LESION, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), TRUNK, ARMS OR LEGS; LESION DIAMETER OVER					
163	11426	EXCISION, BENIGN LESION, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER OVER 4.0 CM					
163	11446	EXCISION, OTHER BENIGN LESION (UNLESS LISTED ELSEWHERE), FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; LESION DIAMETER OVER 4.0 CM					
163	11450	EXCISION OF SKIN AND SUBCUTANEOUS TISSUE FOR HIDRADENITIS, AXILLARY; WITH SIMPLE OR INTERMEDIATE REPAIR					
163	11451	EXCISION OF SKIN AND SUBCUTANEOUS TISSUE FOR HIDRADENITIS, AXILLARY; WITH COMPLEX REPAIR					
163	11462	EXCISION OF SKIN AND SUBCUTANEOUS TISSUE FOR HIDRADENITIS, INGUINAL; WITH SIMPLE OR INTERMEDIATE REPAIR					
163	11463	EXCISION OF SKIN AND SUBCUTANEOUS TISSUE FOR HIDRADENITIS, INGUINAL; WITH COMPLEX REPAIR					
163	11470	EXCISION OF SKIN AND SUBCUTANEOUS TISSUE FOR HIDRADENITIS, PERIANAL, PERINEAL, OR UMBILICAL; WITH SIMPLE OR INTERMEDIATE REPAIR					
163	11471	EXCISION OF SKIN AND SUBCUTANEOUS TISSUE FOR HIDRADENITIS, PERIANAL, PERINEAL, OR UMBILICAL; WITH COMPLEX REPAIR					
163	11606	EXCISION, MALIGNANT LESION, TRUNK, ARMS, OR LEGS; LESION DIAMETER OVER 4.0 CM					
163	11624	EXCISION, MALIGNANT LESION, SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER 3.1 TO 4.0 CM					
163	11626	EXCISION, MALIGNANT LESION, SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER OVER 4.0 CM					
163	11644	EXCISION, MALIGNANT LESION, FACE, EARS, EYELIDS, NOSE, LIPS; LESION DIAMETER 3.1 TO 4.0 CM					
163	11646	EXCISION, MALIGNANT LESION, FACE, EARS, EYELIDS, NOSE, LIPS; LESION DIAMETER OVER 4.0 CM					
163	11752	EXCISION OF NAIL AND NAIL MATRIX, PARTIAL OR COMPLETE, (EG, INGROWN OR DEFORMED NAIL) FOR PERMANENT REMOVAL; WITH AMPUTATION OF TUFT OF DISTAL PHALANX					
163	11771	EXCISION OF PILONIDAL CYST OR SINUS; EXTENSIVE					
163	11772	EXCISION OF PILONIDAL CYST OR SINUS; COMPLICATED					
163	11971	REMOVAL OF TISSUE EXPANDER(S) WITHOUT INSERTION OF PROSTHESIS					
163	15780	DERMABRASION; TOTAL FACE (EG, FOR ACNE SCARRING, FINE WRINKLING, RHYTIDS, GENERAL KERATOSIS)					
163	15781	DERMABRASION; SEGMENTAL, FACE					
163	15782	DERMABRASION; REGIONAL, OTHER THAN FACE					
163	15811	SALABRASION; OVER 20 SQ CM					
163	15838	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY); SUBMENTAL FAT PAD					
163	15920	EXCISION, COCCYGEAL PRESSURE ULCER, WITH COCCYGECTOMY; WITH PRIMARY SUTURE					
163	15931	EXCISION, SACRAL PRESSURE ULCER, WITH PRIMARY SUTURE;					
163	15933	EXCISION, SACRAL PRESSURE ULCER, WITH PRIMARY SUTURE; WITH OSTECTOMY					
163	15940	EXCISION, ISCHIAL PRESSURE ULCER, WITH PRIMARY SUTURE;					
163	15941	EXCISION, ISCHIAL PRESSURE ULCER, WITH PRIMARY SUTURE; WITH OSTECTOMY (ISCHIECTOMY)					
163	15950	EXCISION, TROCHANTERIC PRESSURE ULCER, WITH PRIMARY SUTURE;					
163	15951	EXCISION, TROCHANTERIC PRESSURE ULCER, WITH PRIMARY SUTURE; WITH OSTECTOMY					
163	15999	UNLISTED PROCEDURE, EXCISION PRESSURE ULCER					

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
163	20240	BIOPSY, EXCISIONAL; SUPERFICIAL (EG, ILIUM, STERNUM, SPINOUS PROCESS, RIBS, TROCHANTER OF FEMUR)					
163	20245	BIOPSY, EXCISIONAL; DEEP (EG, HUMERUS, ISCHIUM, FEMUR)					
163	20525	REMOVAL OF FOREIGN BODY IN MUSCLE OR TENDON SHEATH; DEEP OR COMPLICATED					
163	20680	REMOVAL OF IMPLANT; DEEP (EG, BURIED WIRE, PIN, SCREW, METAL BAND, NAIL, ROD OR PLATE)					
163	21555	EXCISION TUMOR, SOFT TISSUE OF NECK OR THORAX; SUBCUTANEOUS					
163	21556	EXCISION TUMOR, SOFT TISSUE OF NECK OR THORAX; DEEP, SUBFASCIAL, INTRAMUSCULAR					
163	21925	BIOPSY, SOFT TISSUE OF BACK OR FLANK; DEEP					
163	21930	EXCISION, TUMOR, SOFT TISSUE OF BACK OR FLANK					
163	21935	RADICAL RESECTION OF TUMOR (EG, MALIGNANT NEOPLASM), SOFT TISSUE OF BACK OR FLANK					
163	22900	EXCISION, ABDOMINAL WALL TUMOR, SUBFASCIAL (EG, DESMOID)					
163	22999	UNLISTED PROCEDURE, ABDOMEN, MUSCULOSKELETAL SYSTEM					
163	23066	BIOPSY, SOFT TISSUE OF SHOULDER AREA; DEEP					
163	23076	EXCISION, TUMOR, SHOULDER AREA; DEEP, SUBFASCIAL, OR INTRAMUSCULAR					
163	23077	RADICAL RESECTION OF TUMOR (EG, MALIGNANT NEOPLASM), SOFT TISSUE OF SHOULDER AREA					
163	23330	REMOVAL OF FOREIGN BODY, SHOULDER; SUBCUTANEOUS					
163	23331	REMOVAL OF FOREIGN BODY, SHOULDER; DEEP (EG, NEER PROSTHESIS REMOVAL)					
163	24066	BIOPSY, SOFT TISSUE OF UPPER ARM OR ELBOW AREA; DEEP					
163	24076	EXCISION, TUMOR, UPPER ARM OR ELBOW AREA; DEEP, SUBFASCIAL OR INTRAMUSCULAR					
163	24077	RADICAL RESECTION OF TUMOR (EG, MALIGNANT NEOPLASM), SOFT TISSUE OF UPPER ARM OR ELBOW AREA					
163	24201	REMOVAL OF FOREIGN BODY, UPPER ARM OR ELBOW AREA; DEEP					
163	25066	BIOPSY, SOFT TISSUE OF FOREARM AND/OR WRIST; DEEP					
163	25076	EXCISION, TUMOR, FOREARM AND/OR WRIST AREA; DEEP, SUBFASCIAL OR INTRAMUSCULAR					
163	25077	RADICAL RESECTION OF TUMOR (EG, MALIGNANT NEOPLASM), SOFT TISSUE OF FOREARM AND/OR WRIST AREA					
163	26115	EXCISION, TUMOR OR VASCULAR MALFORMATION, HAND OR FINGER; SUBCUTANEOUS					
163	26116	EXCISION, TUMOR OR VASCULAR MALFORMATION, HAND OR FINGER; DEEP, SUBFASCIAL, INTRAMUSCULAR					
163	26117	RADICAL RESECTION OF TUMOR (EG, MALIGNANT NEOPLASM), SOFT TISSUE OF HAND OR FINGER					
163	26320	REMOVAL OF IMPLANT FROM FINGER OR HAND					
163	27041	BIOPSY, SOFT TISSUE OF PELVIS AND HIP AREA; DEEP					
163	27047	EXCISION, TUMOR, PELVIS AND HIP AREA; SUBCUTANEOUS					
163	27048	EXCISION, TUMOR, PELVIS AND HIP AREA; DEEP, SUBFASCIAL, INTRAMUSCULAR					
163	27049	RADICAL RESECTION OF TUMOR (EG, MALIGNANT NEOPLASM), SOFT TISSUE OF PELVIS AND HIP AREA					
163	27324	BIOPSY, SOFT TISSUE OF THIGH OR KNEE AREA; DEEP					
163	27327	EXCISION, TUMOR, THIGH OR KNEE AREA; SUBCUTANEOUS					
163	27328	EXCISION, TUMOR, THIGH OR KNEE AREA; DEEP, SUBFASCIAL, OR INTRAMUSCULAR					
163	27329	RADICAL RESECTION OF TUMOR (EG, MALIGNANT NEOPLASM), SOFT TISSUE OF THIGH OR KNEE AREA					
163	27372	REMOVAL OF FOREIGN BODY, DEEP, THIGH REGION OR KNEE AREA					
163	27614	BIOPSY, SOFT TISSUE OF LEG OR ANKLE AREA; DEEP					
163	27618	EXCISION, TUMOR, LEG OR ANKLE AREA; SUBCUTANEOUS					
163	27619	EXCISION, TUMOR, LEG OR ANKLE AREA; DEEP, SUBFASCIAL OR INTRAMUSCULAR					
163	28192	REMOVAL OF FOREIGN BODY, FOOT; DEEP					
163	28193	REMOVAL OF FOREIGN BODY, FOOT; COMPLICATED					
163	69110	EXCISION EXTERNAL EAR; PARTIAL, SIMPLE REPAIR					
163	69145	EXCISION SOFT TISSUE LESION, EXTERNAL AUDITORY CANAL					
163	69205	REMOVAL FOREIGN BODY FROM EXTERNAL AUDITORY CANAL; WITH GENERAL ANESTHESIA					
181	Level I skin repair		T	2.19	$110.97	$43.84	$22.19
181	11760	REPAIR OF NAIL BED					
181	11762	RECONSTRUCTION OF NAIL BED WITH GRAFT					
181	11920	TATTOOING, INTRADERMAL INTRODUCTION OF INSOLUBLE OPAQUE PIGMENTS TO CORRECT COLOR DEFECTS OF SKIN, INCLUDING MICROPIGMENTATION; 6.0 SQ CM OR LESS					
181	11921	TATTOOING, INTRADERMAL INTRODUCTION OF INSOLUBLE OPAQUE PIGMENTS TO CORRECT COLOR DEFECTS OF SKIN, INCLUDING MICROPIGMENTATION; 6.1 TO 20.0 SQ CM					
181	11922	TATTOOING, INTRADERMAL INTRODUCTION OF INSOLUBLE OPAQUE PIGMENTS TO CORRECT COLOR DEFECTS OF SKIN, INCLUDING MICROPIGMENTATION; EACH ADDITIONAL 20.0 SQ CM					
181	11950	SUBCUTANEOUS INJECTION OF ''FILLING'' MATERIAL (EG, COLLAGEN); 1 CC OR LESS					
181	11951	SUBCUTANEOUS INJECTION OF ''FILLING'' MATERIAL (EG, COLLAGEN); 1.1 TO 5.0 CC					
181	11952	SUBCUTANEOUS INJECTION OF ''FILLING'' MATERIAL (EG, COLLAGEN); 5.1 TO 10.0 CC					
181	11954	SUBCUTANEOUS INJECTION OF ''FILLING'' MATERIAL (EG, COLLAGEN); OVER 10.0 CC					
181	12001	SIMPLE REPAIR OF SUPERFICIAL WOUNDS OF SCALP, NECK, AXILLAE, EXTERNAL GENITALIA, TRUNK AND/OR EXTREMITIES (INCLUDING HANDS AND FEET); 2.5 CM OR LESS					
181	12002	SIMPLE REPAIR OF SUPERFICIAL WOUNDS OF SCALP, NECK, AXILLAE, EXTERNAL GENITALIA, TRUNK AND/OR EXTREMITIES (INCLUDING HANDS AND FEET); 2.6 CM TO 7.5 CM					
181	12004	SIMPLE REPAIR OF SUPERFICIAL WOUNDS OF SCALP, NECK, AXILLAE, EXTERNAL GENITALIA, TRUNK AND/OR EXTREMITIES (INCLUDING HANDS AND FEET); 7.6 CM TO 12.5 CM					
181	12005	SIMPLE REPAIR OF SUPERFICIAL WOUNDS OF SCALP, NECK, AXILLAE, EXTERNAL GENITALIA, TRUNK AND/OR EXTREMITIES (INCLUDING HANDS AND FEET); 12.6 CM TO 20.0 CM					
181	12006	SIMPLE REPAIR OF SUPERFICIAL WOUNDS OF SCALP, NECK, AXILLAE, EXTERNAL GENITALIA, TRUNK AND/OR EXTREMITIES (INCLUDING HANDS AND FEET); 20.1 CM TO 30.0 CM					
181	12007	SIMPLE REPAIR OF SUPERFICIAL WOUNDS OF SCALP, NECK, AXILLAE, EXTERNAL GENITALIA, TRUNK AND/OR EXTREMITIES (INCLUDING HANDS AND FEET); OVER 30.0 CM					
181	12011	SIMPLE REPAIR OF SUPERFICIAL WOUNDS OF FACE, EARS, EYELIDS, NOSE, LIPS AND/OR MUCOUS MEMBRANES; 2.5 CM OR LESS					
181	12013	SIMPLE REPAIR OF SUPERFICIAL WOUNDS OF FACE, EARS, EYELIDS, NOSE, LIPS AND/OR MUCOUS MEMBRANES; 2.6 CM TO 5.0 CM					
181	12014	SIMPLE REPAIR OF SUPERFICIAL WOUNDS OF FACE, EARS, EYELIDS, NOSE, LIPS AND/OR MUCOUS MEMBRANES; 5.1 CM TO 7.5 CM					
181	12015	SIMPLE REPAIR OF SUPERFICIAL WOUNDS OF FACE, EARS, EYELIDS, NOSE, LIPS AND/OR MUCOUS MEMBRANES; 7.6 CM TO 12.5 CM					
181	12016	SIMPLE REPAIR OF SUPERFICIAL WOUNDS OF FACE, EARS, EYELIDS, NOSE, LIPS AND/OR MUCOUS MEMBRANES; 12.6 CM TO 20.0 CM					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
181	12017	SIMPLE REPAIR OF SUPERFICIAL WOUNDS OF FACE, EARS, EYELIDS, NOSE, LIPS AND/OR MUCOUS MEMBRANES; 20.1 CM TO 30.0 CM					
181	12018	SIMPLE REPAIR OF SUPERFICIAL WOUNDS OF FACE, EARS, EYELIDS, NOSE, LIPS AND/OR MUCOUS MEMBRANES; OVER 30.0 CM					
181	12020	TREATMENT OF SUPERFICIAL WOUND DEHISCENCE; SIMPLE CLOSURE					
181	12021	TREATMENT OF SUPERFICIAL WOUND DEHISCENCE; WITH PACKING					
181	12031	LAYER CLOSURE OF WOUNDS OF SCALP, AXILLAE, TRUNK AND/OR EXTREMITIES (EXCLUDING HANDS AND FEET); 2.5 CM OR LESS					
181	12032	LAYER CLOSURE OF WOUNDS OF SCALP, AXILLAE, TRUNK AND/OR EXTREMITIES (EXCLUDING HANDS AND FEET); 2.6 CM TO 7.5 CM					
181	12034	LAYER CLOSURE OF WOUNDS OF SCALP, AXILLAE, TRUNK AND/OR EXTREMITIES (EXCLUDING HANDS AND FEET); 7.6 CM TO 12.5 CM					
181	12035	LAYER CLOSURE OF WOUNDS OF SCALP, AXILLAE, TRUNK AND/OR EXTREMITIES (EXCLUDING HANDS AND FEET); 12.6 CM TO 20.0 CM					
181	12036	LAYER CLOSURE OF WOUNDS OF SCALP, AXILLAE, TRUNK AND/OR EXTREMITIES (EXCLUDING HANDS AND FEET); 20.1 CM TO 30.0 CM					
181	12041	LAYER CLOSURE OF WOUNDS OF NECK, HANDS, FEET AND/OR EXTERNAL GENITALIA; 2.5 CM OR LESS					
181	12042	LAYER CLOSURE OF WOUNDS OF NECK, HANDS, FEET AND/OR EXTERNAL GENITALIA; 2.6 CM TO 7.5 CM					
181	12044	LAYER CLOSURE OF WOUNDS OF NECK, HANDS, FEET AND/OR EXTERNAL GENITALIA; 7.6 CM TO 12.5 CM					
181	12045	LAYER CLOSURE OF WOUNDS OF NECK, HANDS, FEET AND/OR EXTERNAL GENITALIA; 12.6 CM TO 20.0 CM					
181	12046	LAYER CLOSURE OF WOUNDS OF NECK, HANDS, FEET AND/OR EXTERNAL GENITALIA; 20.1 CM TO 30.0 CM					
181	12051	LAYER CLOSURE OF WOUNDS OF FACE, EARS, EYELIDS, NOSE, LIPS AND/OR MUCOUS MEMBRANES; 2.5 CM OR LESS					
181	12052	LAYER CLOSURE OF WOUNDS OF FACE, EARS, EYELIDS, NOSE, LIPS AND/OR MUCOUS MEMBRANES; 2.6 CM TO 5.0 CM					
181	12053	LAYER CLOSURE OF WOUNDS OF FACE, EARS, EYELIDS, NOSE, LIPS AND/OR MUCOUS MEMBRANES; 5.1 CM TO 7.5 CM					
181	12054	LAYER CLOSURE OF WOUNDS OF FACE, EARS, EYELIDS, NOSE, LIPS AND/OR MUCOUS MEMBRANES; 7.6 CM TO 12.5 CM					
181	12055	LAYER CLOSURE OF WOUNDS OF FACE, EARS, EYELIDS, NOSE, LIPS AND/OR MUCOUS MEMBRANES; 12.6 CM TO 20.0 CM					
181	12056	LAYER CLOSURE OF WOUNDS OF FACE, EARS, EYELIDS, NOSE, LIPS AND/OR MUCOUS MEMBRANES; 20.1 CM TO 30.0 CM					
181	20500	INJECTION OF SINUS TRACT; THERAPEUTIC (SEPARATE PROCEDURE)					
182	Level II skin repair		T	4.	$202.68	$84.98	$40.54
182	13100	REPAIR, COMPLEX, TRUNK; 1.1 CM TO 2.5 CM					
182	13101	REPAIR, COMPLEX, TRUNK; 2.6 CM TO 7.5 CM					
182	13120	REPAIR, COMPLEX, SCALP, ARMS, AND/OR LEGS; 1.1 CM TO 2.5 CM					
182	13121	REPAIR, COMPLEX, SCALP, ARMS, AND/OR LEGS; 2.6 CM TO 7.5 CM					
182	13131	REPAIR, COMPLEX, FOREHEAD, CHEEKS, CHIN, MOUTH, NECK, AXILLAE, GENITALIA, HANDS AND/OR FEET; 1.1 CM TO 2.5 CM					
182	13132	REPAIR, COMPLEX, FOREHEAD, CHEEKS, CHIN, MOUTH, NECK, AXILLAE, GENITALIA, HANDS AND/OR FEET; 2.6 CM TO 7.5 CM					
182	13150	REPAIR, COMPLEX, EYELIDS, NOSE, EARS AND/OR LIPS; 1.0 CM OR LESS					
182	13151	REPAIR, COMPLEX, EYELIDS, NOSE, EARS AND/OR LIPS; 1.1 CM TO 2.5 CM					
182	13152	REPAIR, COMPLEX, EYELIDS, NOSE, EARS AND/OR LIPS; 2.6 CM TO 7.5 CM					
182	13160	SECONDARY CLOSURE OF SURGICAL WOUND OR DEHISCENCE, EXTENSIVE OR COMPLICATED					
182	13300	REPAIR, UNUSUAL, COMPLICATED, OVER 7.5 CM, ANY AREA					
182	43870	CLOSURE OF GASTROSTOMY, SURGICAL					
183	Level III skin repair		T	11.17	$565.98	$286.46	$113.20
183	11960	INSERTION OF TISSUE EXPANDER(S) FOR OTHER THAN BREAST, INCLUDING SUBSEQUENT EXPANSION					
183	11970	REPLACEMENT OF TISSUE EXPANDER WITH PERMANENT PROSTHESIS					
183	12037	LAYER CLOSURE OF WOUNDS OF SCALP, AXILLAE, TRUNK AND/OR EXTREMITIES (EXCLUDING HANDS AND FEET); OVER 30.0 CM					
183	12047	LAYER CLOSURE OF WOUNDS OF NECK, HANDS, FEET AND/OR EXTERNAL GENITALIA; OVER 30.0 CM					
183	12057	LAYER CLOSURE OF WOUNDS OF FACE, EARS, EYELIDS, NOSE, LIPS AND/OR MUCOUS MEMBRANES; OVER 30.0 CM					
183	14000	ADJACENT TISSUE TRANSFER OR REARRANGEMENT, TRUNK; DEFECT 10 SQ CM OR LESS					
183	14001	ADJACENT TISSUE TRANSFER OR REARRANGEMENT, TRUNK; DEFECT 10.1 SQ CM TO 30.0 SQ CM					
183	14020	ADJACENT TISSUE TRANSFER OR REARRANGEMENT, SCALP, ARMS AND/ OR LEGS; DEFECT 10 SQ CM OR LESS					
183	14021	ADJACENT TISSUE TRANSFER OR REARRANGEMENT, SCALP, ARMS AND/ OR LEGS; DEFECT 10.1 SQ CM TO 30.0 SQ CM					
183	14040	ADJACENT TISSUE TRANSFER OR REARRANGEMENT, FOREHEAD, CHEEKS, CHIN, MOUTH, NECK, AXILLAE, GENITALIA, HANDS AND/ OR FEET; DEFECT 10 SQ CM OR LESS					
183	14041	ADJACENT TISSUE TRANSFER OR REARRANGEMENT, FOREHEAD, CHEEKS, CHIN, MOUTH, NECK, AXILLAE, GENITALIA, HANDS AND/ OR FEET; DEFECT 10.1 SQ CM TO 30.0 SQ CM					
183	14060	ADJACENT TISSUE TRANSFER OR REARRANGEMENT, EYELIDS, NOSE, EARS AND/OR LIPS; DEFECT 10 SQ CM OR LESS					
183	14061	ADJACENT TISSUE TRANSFER OR REARRANGEMENT, EYELIDS, NOSE, EARS AND/OR LIPS; DEFECT 10.1 SQ CM TO 30.0 SQ CM					
183	14300	ADJACENT TISSUE TRANSFER OR REARRANGEMENT, MORE THAN 30 SQ CM, UNUSUAL OR COMPLICATED, ANY AREA					
183	14350	FILLETED FINGER OR TOE FLAP, INCLUDING PREPARATION OF RECIPIENT SITE					
183	15000	EXCISIONAL PREPARATION OR CREATION OF RECIPIENT SITE BY EXCISION OF ESSENTIALLY INTACT SKIN (INCLUDING SUBCUTANEOUS TISSUES), SCAR, OR OTHER LESION PRIOR TO REPAIR WITH FREE SKIN GRAFT (LIST AS SEPARATE SERVICE IN ADDITION TO SKIN GRAFT)					
183	15050	PINCH GRAFT, SINGLE OR MULTIPLE, TO COVER SMALL ULCER, TIP OF DIGIT, OR OTHER MINIMAL OPEN AREA (EXCEPT ON FACE), UP TO DEFECT SIZE 2 CM DIAMETER					
183	15100	SPLIT GRAFT, TRUNK, SCALP, ARMS, LEGS, HANDS, AND/OR FEET (EXCEPT MULTIPLE DIGITS); 100 SQ CM OR LESS, OR EACH ONE PERCENT OF BODY AREA OF INFANTS AND CHILDREN (EXCEPT 15050)					
183	15101	SPLIT GRAFT, TRUNK, SCALP, ARMS, LEGS, HANDS, AND/OR FEET (EXCEPT MULTIPLE DIGITS); EACH ADDITIONAL 100 SQ CM, OR EACH ONE PERCENT OF BODY AREA OF INFANTS AND CHILDREN, OR PART THEREOF					
183	15120	SPLIT GRAFT, FACE, EYELIDS, MOUTH, NECK, EARS, ORBITS, GENITALIA, AND/OR MULTIPLE DIGITS; 100 SQ CM OR LESS, OR EACH ONE PERCENT OF BODY AREA OF INFANTS AND CHILDREN (EXCEPT 15050)					
183	15121	SPLIT GRAFT, FACE, EYELIDS, MOUTH, NECK, EARS, ORBITS, GENITALIA, AND/OR MULTIPLE DIGITS; EACH ADDITIONAL 100 SQ CM, OR EACH ONE PERCENT OF BODY AREA OF INFANTS AND CHILDREN, OR PART THEREOF					
183	15200	FULL THICKNESS GRAFT, FREE, INCLUDING DIRECT CLOSURE OF DONOR SITE, TRUNK; 20 SQ CM OR LESS					
183	15201	FULL THICKNESS GRAFT, FREE, INCLUDING DIRECT CLOSURE OF DONOR SITE, TRUNK; EACH ADDITIONAL 20 SQ CM					
183	15220	FULL THICKNESS GRAFT, FREE, INCLUDING DIRECT CLOSURE OF DONOR SITE, SCALP, ARMS, AND/OR LEGS; 20 SQ CM OR LESS					
183	15221	FULL THICKNESS GRAFT, FREE, INCLUDING DIRECT CLOSURE OF DONOR SITE, SCALP, ARMS, AND/OR LEGS; EACH ADDITIONAL 20 SQ CM					
183	15240	FULL THICKNESS GRAFT, FREE, INCLUDING DIRECT CLOSURE OF DONOR SITE, FOREHEAD, CHEEKS, CHIN, MOUTH, NECK, AXILLAE, GENITALIA, HANDS, AND/OR FEET; 20 SQ CM OR LESS					

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
183	15241	FULL THICKNESS GRAFT, FREE, INCLUDING DIRECT CLOSURE OF DONOR SITE, FOREHEAD, CHEEKS, CHIN, MOUTH, NECK, AXILLAE, GENITALIA, HANDS, AND/OR FEET; EACH ADDITIONAL 20 SQ CM					
183	15260	FULL THICKNESS GRAFT, FREE, INCLUDING DIRECT CLOSURE OF DONOR SITE, NOSE, EARS, EYELIDS, AND/OR LIPS; 20 SQ CM OR LESS					
183	15261	FULL THICKNESS GRAFT, FREE, INCLUDING DIRECT CLOSURE OF DONOR SITE, NOSE, EARS, EYELIDS, AND/OR LIPS; EACH ADDITIONAL 20 SQ CM					
183	15350	APPLICATION OF ALLOGRAFT, SKIN					
183	15400	APPLICATION OF XENOGRAFT, SKIN					
183	15570	FORMATION OF DIRECT OR TUBED PEDICLE, WITH OR WITHOUT TRANSFER; TRUNK					
183	15572	FORMATION OF DIRECT OR TUBED PEDICLE, WITH OR WITHOUT TRANSFER; SCALP, ARMS, OR LEGS					
183	15574	FORMATION OF DIRECT OR TUBED PEDICLE, WITH OR WITHOUT TRANSFER; FOREHEAD, CHEEKS, CHIN, MOUTH, NECK, AXILLAE, GENITALIA, HANDS OR FEET					
183	15576	FORMATION OF DIRECT OR TUBED PEDICLE, WITH OR WITHOUT TRANSFER; EYELIDS, NOSE, EARS, LIPS, OR INTRAORAL					
183	15580	CROSS FINGER FLAP, INCLUDING FREE GRAFT TO DONOR SITE					
183	15600	DELAY OF FLAP OR SECTIONING OF FLAP (DIVISION AND INSET); AT TRUNK					
183	15610	DELAY OF FLAP OR SECTIONING OF FLAP (DIVISION AND INSET); AT SCALP, ARMS, OR LEGS					
183	15620	DELAY OF FLAP OR SECTIONING OF FLAP (DIVISION AND INSET); AT FOREHEAD, CHEEKS, CHIN, NECK, AXILLAE, GENITALIA, HANDS (EXCEPT 15625), OR FEET					
183	15625	DELAY OF FLAP OR SECTIONING OF FLAP (DIVISION AND INSET); SECTION PEDICLE OF CROSS FINGER FLAP					
183	15630	DELAY OF FLAP OR SECTIONING OF FLAP (DIVISION AND INSET); AT EYELIDS, NOSE, EARS, OR LIPS					
183	15650	TRANSFER, INTERMEDIATE, OF ANY PEDICLE FLAP (EG, ABDOMEN TO WRIST, ''WALKING'' TUBE), ANY LOCATION					
183	15775	PUNCH GRAFT FOR HAIR TRANSPLANT; 1 TO 15 PUNCH GRAFTS					
183	15776	PUNCH GRAFT FOR HAIR TRANSPLANT; MORE THAN 15 PUNCH GRAFTS					
183	15819	CERVICOPLASTY					
183	15820	BLEPHAROPLASTY, LOWER EYELID					
183	15821	BLEPHAROPLASTY, LOWER EYELID; WITH EXTENSIVE HERNIATED FAT PAD					
183	15822	BLEPHAROPLASTY, UPPER EYELID					
183	15823	BLEPHAROPLASTY, UPPER EYELID; WITH EXCESSIVE SKIN WEIGHTING DOWN LID					
183	15825	RHYTIDECTOMY; NECK WITH PLATYSMAL TIGHTENING (PLATYSMAL FLAP, ''P-FLAP'')					
183	15829	RHYTIDECTOMY; SUPERFICIAL MUSCULOAPONEUROTIC SYSTEM (SMAS) FLAP					
183	15835	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY); BUTTOCK					
183	20910	CARTILAGE GRAFT; COSTOCHONDRAL					
183	20912	CARTILAGE GRAFT; NASAL SEPTUM					
183	20920	FASCIA LATA GRAFT; BY STRIPPER					
183	20922	FASCIA LATA GRAFT; BY INCISION AND AREA EXPOSURE, COMPLEX OR SHEET					
183	20926	TISSUE GRAFTS, OTHER (EG, PARATENON, FAT, DERMIS)					
183	23921	DISARTICULATION OF SHOULDER; SECONDARY CLOSURE OR SCAR REVISION					
183	25929	TRANSMETACARPAL AMPUTATION; SECONDARY CLOSURE OR SCAR REVISION					
183	44312	REVISION OF ILEOSTOMY; SIMPLE (RELEASE OF SUPERFICIAL SCAR) (SEPARATE PROCEDURE)					
183	44340	REVISION OF COLOSTOMY; SIMPLE (RELEASE OF SUPERFICIAL SCAR) (SEPARATE PROCEDURE)					
183	65270	REPAIR OF LACERATION; CONJUNCTIVA, WITH OR WITHOUT NONPERFORATING LACERATION SCLERA, DIRECT CLOSURE					
184	Level IV skin repair		T	15.17	$768.66	$396.40	$153.73
184	15732	MUSCLE, MYOCUTANEOUS, OR FASCIOCUTANEOUS FLAP; HEAD AND NECK (EG, TEMPORALIS, MASSETER, STERNOCLEIDOMASTOID, LEVATOR SCAPULAE)					
184	15734	MUSCLE, MYOCUTANEOUS, OR FASCIOCUTANEOUS FLAP; TRUNK					
184	15736	MUSCLE, MYOCUTANEOUS, OR FASCIOCUTANEOUS FLAP; UPPER EXTREMITY					
184	15738	MUSCLE, MYOCUTANEOUS, OR FASCIOCUTANEOUS FLAP; LOWER EXTREMITY					
184	15740	FLAP; ISLAND PEDICLE					
184	15750	FLAP; NEUROVASCULAR PEDICLE					
184	15760	GRAFT; COMPOSITE (EG, FULL THICKNESS OF EXTERNAL EAR OR NASAL ALA), INCLUDING PRIMARY CLOSURE, DONOR AREA					
184	15770	GRAFT; DERMA-FAT-FASCIA					
184	15824	RHYTIDECTOMY; FOREHEAD					
184	15826	RHYTIDECTOMY; GLABELLAR FROWN LINES					
184	15828	RHYTIDECTOMY; CHEEK, CHIN, AND NECK					
184	15831	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY); ABDOMEN (ABDOMINOPLASTY)					
184	15832	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY); THIGH					
184	15833	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY); LEG					
184	15834	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY); HIP					
184	15836	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY); ARM					
184	15837	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY); FOREARM OR HAND					
184	15839	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY); OTHER AREA					
184	15840	GRAFT FOR FACIAL NERVE PARALYSIS; FREE FASCIA GRAFT (INCLUDING OBTAINING FASCIA)					
184	15841	GRAFT FOR FACIAL NERVE PARALYSIS; FREE MUSCLE GRAFT (INCLUDING OBTAINING GRAFT)					
184	15842	GRAFT FOR FACIAL NERVE PARALYSIS; FREE MUSCLE GRAFT BY MICROSURGICAL TECHNIQUE					
184	15845	GRAFT FOR FACIAL NERVE PARALYSIS; REGIONAL MUSCLE TRANSFER					
184	15876	SUCTION ASSISTED LIPECTOMY; HEAD AND NECK					
184	15877	SUCTION ASSISTED LIPECTOMY; TRUNK					
184	15878	SUCTION ASSISTED LIPECTOMY; UPPER EXTREMITY					
184	15879	SUCTION ASSISTED LIPECTOMY; LOWER EXTREMITY					
184	15922	EXCISION, COCCYGEAL PRESSURE ULCER, WITH COCCYGECTOMY; WITH FLAP CLOSURE					
184	15934	EXCISION, SACRAL PRESSURE ULCER, WITH SKIN FLAP CLOSURE					
184	15935	EXCISION, SACRAL PRESSURE ULCER, WITH SKIN FLAP CLOSURE; WITH OSTECTOMY					
184	15936	EXCISION, SACRAL PRESSURE ULCER, WITH MUSCLE OR MYOCUTANEOUS FLAP CLOSURE					
184	15937	EXCISION, SACRAL PRESSURE ULCER, WITH MUSCLE OR MYOCUTANEOUS FLAP CLOSURE; WITH OSTECTOMY					
184	15944	EXCISION, ISCHIAL PRESSURE ULCER, WITH SKIN FLAP CLOSURE					

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
184	15945	EXCISION, ISCHIAL PRESSURE ULCER, WITH SKIN FLAP CLOSURE; WITH OSTECTOMY					
184	15946	EXCISION, ISCHIAL PRESSURE ULCER, WITH OSTECTOMY, WITH MUSCLE OR MYOCUTANEOUS FLAP CLOSURE					
184	15952	EXCISION, TROCHANTERIC PRESSURE ULCER, WITH SKIN FLAP CLOSURE					
184	15953	EXCISION, TROCHANTERIC PRESSURE ULCER, WITH SKIN FLAP CLOSURE; WITH OSTECTOMY					
184	15956	EXCISION, TROCHANTERIC PRESSURE ULCER, WITH MUSCLE OR MYOCUTANEOUS FLAP CLOSURE					
184	15958	EXCISION, TROCHANTERIC PRESSURE ULCER, WITH MUSCLE OR MYOCUTANEOUS FLAP CLOSURE; WITH OSTECTOMY					
197	Incision/excision breast		T	12.13	$614.62	$310.75	$122.92
197	19101	BIOPSY OF BREAST; INCISIONAL					
197	19110	NIPPLE EXPLORATION, WITH OR WITHOUT EXCISION OF A SOLITARY LACTIFEROUS DUCT OR A PAPILLOMA LACTIFEROUS DUCT					
197	19112	EXCISION OF LACTIFEROUS DUCT FISTULA					
197	19120	EXCISION OF CYST, FIBROADENOMA, OR OTHER BENIGN OR MALIGNANT TUMOR ABERRANT BREAST TISSUE, DUCT LESION, NIPPLE OR AREOLAR LESION (EXCEPT 19140), MALE OR FEMALE, ONE OR MORE LESIONS					
197	19125	EXCISION OF BREAST LESION IDENTIFIED BY PREOPERATIVE PLACEMENT OF RADIOLOGICAL MARKER; SINGLE LESION					
197	19126	EXCISION OF BREAST LESION IDENTIFIED BY PREOPERATIVE PLACEMENT OF RADIOLOGICAL MARKER; EACH ADDITIONAL LESION SEPARATELY IDENTIFIED BY A RADIOLOGICAL MARKER					
197	19140	MASTECTOMY FOR GYNECOMASTIA					
197	19290	PREOPERATIVE PLACEMENT OF NEEDLE LOCALIZATION WIRE, BREAST					
197	19291	PREOPERATIVE PLACEMENT OF NEEDLE LOCALIZATION WIRE, BREAST; EACH ADDITIONAL LESION					
197	19396	PREPARATION OF MOULAGE FOR CUSTOM BREAST IMPLANT					
197	19499	UNLISTED PROCEDURE, BREAST					
198	Breast reconstruction/mastectomy		T	19.17	$971.33	$530.20	$194.27
198	19160	MASTECTOMY, PARTIAL;					
198	19162	MASTECTOMY, PARTIAL; WITH AXILLARY LYMPHADENECTOMY					
198	19180	MASTECTOMY, SIMPLE, COMPLETE					
198	19182	MASTECTOMY, SUBCUTANEOUS					
198	19316	MASTOPEXY					
198	19318	REDUCTION MAMMAPLASTY					
198	19324	MAMMAPLASTY, AUGMENTATION; WITHOUT PROSTHETIC IMPLANT					
198	19325	MAMMAPLASTY, AUGMENTATION; WITH PROSTHETIC IMPLANT					
198	19328	REMOVAL OF INTACT MAMMARY IMPLANT					
198	19330	REMOVAL OF MAMMARY IMPLANT MATERIAL					
198	19340	IMMEDIATE INSERTION OF BREAST PROSTHESIS FOLLOWING MASTOPEXY, MASTECTOMY OR IN RECONSTRUCTION					
198	19342	DELAYED INSERTION OF BREAST PROSTHESIS FOLLOWING MASTOPEXY, MASTECTOMY OR IN RECONSTRUCTION					
198	19350	NIPPLE/AREOLA RECONSTRUCTION					
198	19355	CORRECTION OF INVERTED NIPPLES					
198	19357	BREAST RECONSTRUCTION, IMMEDIATE OR DELAYED, WITH TISSUE EXPANDER, INCLUDING SUBSEQUENT EXPANSION					
198	19366	BREAST RECONSTRUCTION WITH OTHER TECHNIQUE					
198	19370	OPEN PERIPROSTHETIC CAPSULOTOMY, BREAST					
198	19371	PERIPROSTHETIC CAPSULECTOMY, BREAST					
198	19380	REVISION OF RECONSTRUCTED BREAST					
200	Arthrocentesis & Ligament/Tendon Injection		T	1.89	$95.77	$39.10	$19.15
200	20550	INJECTION, TENDON SHEATH, LIGAMENT, TRIGGER POINTS OR GANGLION CYST					
200	20600	ARTHROCENTESIS, ASPIRATION AND/OR INJECTION; SMALL JOINT, BURSA OR GANGLION CYST (EG, FINGERS, TOES)					
200	20605	ARTHROCENTESIS, ASPIRATION AND/OR INJECTION; INTERMEDIATE JOINT, BURSA OR GANGLION CYST (EG, TEMPOROMANDIBULAR, ACROMIOCLAVICULAR, WRIST, ELBOW OR ANKLE, OLECRANON BURSA)					
200	20610	ARTHROCENTESIS, ASPIRATION AND/OR INJECTION; MAJOR JOINT OR BURSA (EG, SHOULDER, HIP, KNEE JOINT, SUBACROMIAL BURSA)					
207	Closed treatment fracture finger/toe/trunk		T	1.70	$86.14	$31.64	$17.23
207	21800	CLOSED TREATMENT OF RIB FRACTURE, UNCOMPLICATED, EACH					
207	21820	CLOSED TREATMENT OF STERNUM FRACTURE					
207	21899	UNLISTED PROCEDURE, NECK OR THORAX					
207	22305	CLOSED TREATMENT OF VERTEBRAL PROCESS FRACTURE(S)					
207	22310	CLOSED TREATMENT OF VERTEBRAL BODY FRACTURE(S), WITHOUT MANIPULATION, REQUIRING AND INCLUDING CASTING OR BRACING					
207	22315	CLOSED TREATMENT OF VERTEBRAL FRACTURE(S) AND/OR DISLOCATION(S) REQUIRING CASTING OR BRACING, WITH AND INCLUDING CASTING AND/OR BRACING, WITH OR WITHOUT ANESTHESIA, BY MANIPULATION OR TRACTION					
207	22899	UNLISTED PROCEDURE, SPINE					
207	23500	CLOSED TREATMENT OF CLAVICULAR FRACTURE; WITHOUT MANIPULATION					
207	23505	CLOSED TREATMENT OF CLAVICULAR FRACTURE; WITH MANIPULATION					
207	23520	CLOSED TREATMENT OF STERNOCLAVICULAR DISLOCATION; WITHOUT MANIPULATION					
207	23525	WITH MANIPULATION					
207	23540	CLOSED TREATMENT OF ACROMIOCLAVICULAR DISLOCATION; WITHOUT MANIPULATION					
207	23545	CLOSED TREATMENT OF ACROMIOCLAVICULAR DISLOCATION; WITH MANIPULATION					
207	23570	CLOSED TREATMENT OF SCAPULAR FRACTURE; WITHOUT MANIPULATION					
207	23575	CLOSED TREATMENT OF SCAPULAR FRACTURE; WITH MANIPULATION, WITH OR WITHOUT SKELETAL TRACTION (WITH OR WITHOUT SHOULDER JOINT INVOLVEMENT)					
207	23650	CLOSED TREATMENT OF SHOULDER DISLOCATION, WITH MANIPULATION; WITHOUT ANESTHESIA					
207	23929	UNLISTED PROCEDURE, SHOULDER					
207	26700	CLOSED TREATMENT OF METACARPOPHALANGEAL DISLOCATION, SINGLE, WITH MANIPULATION; WITHOUT ANESTHESIA					
207	26720	CLOSED TREATMENT OF PHALANGEAL SHAFT FRACTURE, PROXIMAL OR MIDDLE PHALANX, FINGER OR THUMB; WITHOUT MANIPULATION, EACH					
207	26725	CLOSED TREATMENT OF PHALANGEAL SHAFT FRACTURE, PROXIMAL OR MIDDLE PHALANX, FINGER OR THUMB; WITH MANIPULATION, WITH OR WITHOUT SKIN OR SKELETAL TRACTION, EACH					

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
207	26740	CLOSED TREATMENT OF ARTICULAR FRACTURE, INVOLVING METACARPOPHALANGEAL OR INTERPHALANGEAL JOINT; WITHOUT MANIPULATION, EACH					
207	26750	CLOSED TREATMENT OF DISTAL PHALANGEAL FRACTURE, FINGER OR THUMB; WITHOUT MANIPULATION, EACH					
207	26755	CLOSED TREATMENT OF DISTAL PHALANGEAL FRACTURE, FINGER OR THUMB; WITH MANIPULATION, EACH					
207	26770	CLOSED TREATMENT OF INTERPHALANGEAL JOINT DISLOCATION, SINGLE, WITH MANIPULATION; WITHOUT ANESTHESIA					
207	26989	UNLISTED PROCEDURE, HANDS OR FINGERS					
207	27200	CLOSED TREATMENT OF COCCYGEAL FRACTURE					
207	27299	UNLISTED PROCEDURE, PELVIS OR HIP JOINT					
207	28490	CLOSED TREATMENT OF FRACTURE GREAT TOE, PHALANX OR PHALANGES; WITHOUT MANIPULATION					
207	28495	CLOSED TREATMENT OF FRACTURE GREAT TOE, PHALANX OR PHALANGES; WITH MANIPULATION					
207	28510	CLOSED TREATMENT OF FRACTURE, PHALANX OR PHALANGES, OTHER THAN GREAT TOE; WITHOUT MANIPULATION, EACH					
207	28515	CLOSED TREATMENT OF FRACTURE, PHALANX OR PHALANGES, OTHER THAN GREAT TOE; WITH MANIPULATION, EACH					
207	28630	CLOSED TREATMENT OF METATARSOPHALANGEAL JOINT DISLOCATION; WITHOUT ANESTHESIA					
207	28660	CLOSED TREATMENT OF INTERPHALANGEAL JOINT DISLOCATION; WITHOUT ANESTHESIA					
207	28899	UNLISTED PROCEDURE, FOOT OR TOES					
207	31585	TREATMENT OF CLOSED LARYNGEAL FRACTURE; WITHOUT MANIPULATION					
207	31599	UNLISTED PROCEDURE, LARYNX					
209	Closed treatment fracture/dislocation/except finger/toe/trunk		T	1.94	$98.30	$37.29	$19.66
209	23600	CLOSED TREATMENT OF PROXIMAL HUMERAL (SURGICAL OR ANATOMICAL NECK) FRACTURE; WITHOUT MANIPULATION					
209	23605	CLOSED TREATMENT OF PROXIMAL HUMERAL (SURGICAL OR ANATOMICAL NECK) FRACTURE; WITH MANIPULATION, WITH OR WITHOUT SKELETAL TRACTION					
209	23620	CLOSED TREATMENT OF GREATER TUBEROSITY FRACTURE; WITHOUT MANIPULATION					
209	23625	CLOSED TREATMENT OF GREATER TUBEROSITY FRACTURE; WITH MANIPULATION					
209	23665	CLOSED TREATMENT OF SHOULDER DISLOCATION, WITH FRACTURE OF GREATER TUBEROSITY, WITH MANIPULATION					
209	23675	CLOSED TREATMENT OF SHOULDER DISLOCATION, WITH SURGICAL OR ANATOMICAL NECK FRACTURE, WITH MANIPULATION					
209	24500	CLOSED TREATMENT OF HUMERAL SHAFT FRACTURE; WITHOUT MANIPULATION					
209	24505	CLOSED TREATMENT OF HUMERAL SHAFT FRACTURE; WITH MANIPULATION, WITH OR WITHOUT SKELETAL TRACTION					
209	24530	CLOSED TREATMENT OF SUPRACONDYLAR OR TRANSCONDYLAR HUMERAL FRACTURE, WITH OR WITHOUT INTERCONDYLAR EXTENSION; WITHOUT MANIPULATION					
209	24535	CLOSED TREATMENT OF SUPRACONDYLAR OR TRANSCONDYLAR HUMERAL FRACTURE, WITH OR WITHOUT INTERCONDYLAR EXTENSION; WITH MANIPULATION, WITH OR WITHOUT SKIN OR SKELETAL TRACTION					
209	24560	CLOSED TREATMENT OF HUMERAL EPICONDYLAR FRACTURE, MEDIAL OR LATERAL; WITHOUT MANIPULATION					
209	24565	CLOSED TREATMENT OF HUMERAL EPICONDYLAR FRACTURE, MEDIAL OR LATERAL; WITH MANIPULATION					
209	24576	CLOSED TREATMENT OF HUMERAL CONDYLAR FRACTURE, MEDIAL OR LATERAL; WITHOUT MANIPULATION					
209	24577	CLOSED TREATMENT OF HUMERAL CONDYLAR FRACTURE, MEDIAL OR LATERAL; WITH MANIPULATION					
209	24600	TREATMENT OF CLOSED ELBOW DISLOCATION; WITHOUT ANESTHESIA					
209	24620	CLOSED TREATMENT OF MONTEGGIA TYPE OF FRACTURE DISLOCATION AT ELBOW (FRACTURE PROXIMAL END OF ULNA WITH DISLOCATION OF RADIAL HEAD), WITH MANIPULATION					
209	24640	CLOSED TREATMENT OF RADIAL HEAD SUBLUXATION IN CHILD, ''NURSEMAID ELBOW'', WITH MANIPULATION					
209	24650	CLOSED TREATMENT OF RADIAL HEAD OR NECK FRACTURE; WITHOUT MANIPULATION					
209	24655	CLOSED TREATMENT OF RADIAL HEAD OR NECK FRACTURE; WITH MANIPULATION					
209	24670	CLOSED TREATMENT OF ULNAR FRACTURE, PROXIMAL END (OLECRANON PROCESS); WITHOUT MANIPULATION					
209	24675	CLOSED TREATMENT OF ULNAR FRACTURE, PROXIMAL END (OLECRANON PROCESS); WITH MANIPULATION					
209	24999	UNLISTED PROCEDURE, HUMERUS OR ELBOW					
209	25500	CLOSED TREATMENT OF RADIAL SHAFT FRACTURE; WITHOUT MANIPULATION					
209	25505	CLOSED TREATMENT OF RADIAL SHAFT FRACTURE; WITH MANIPULATION					
209	25520	CLOSED TREATMENT OF RADIAL SHAFT FRACTURE, WITH DISLOCATION OF DISTAL RADIO-ULNAR JOINT (GALEAZZI FRACTURE/DISLOCATION)					
209	25530	CLOSED TREATMENT OF ULNAR SHAFT FRACTURE; WITHOUT MANIPULATION					
209	25535	CLOSED TREATMENT OF ULNAR SHAFT FRACTURE; WITH MANIPULATION					
209	25560	CLOSED TREATMENT OF RADIAL AND ULNAR SHAFT FRACTURES; WITHOUT MANIPULATION					
209	25565	CLOSED TREATMENT OF RADIAL AND ULNAR SHAFT FRACTURES; WITH MANIPULATION					
209	25600	CLOSED TREATMENT OF DISTAL RADIAL FRACTURE (EG, COLLES OR SMITH TYPE) OR EPIPHYSEAL SEPARATION, WITH OR WITHOUT FRACTURE OF ULNAR STYLOID; WITHOUT MANIPULATION					
209	25605	CLOSED TREATMENT OF DISTAL RADIAL FRACTURE (EG, COLLES OR SMITH TYPE) OR EPIPHYSEAL SEPARATION, WITH OR WITHOUT FRACTURE OF ULNAR STYLOID; WITH MANIPULATION					
209	25622	CLOSED TREATMENT OF CARPAL SCAPHOID (NAVICULAR) FRACTURE; WITHOUT MANIPULATION					
209	25624	CLOSED TREATMENT OF CARPAL SCAPHOID (NAVICULAR) FRACTURE; WITH MANIPULATION					
209	25630	CLOSED TREATMENT OF CARPAL BONE FRACTURE (EXCLUDING CARPAL SCAPHOID (NAVICULAR)); WITHOUT MANIPULATION, EACH BONE					
209	25635	CLOSED TREATMENT OF CARPAL BONE FRACTURE (EXCLUDING CARPAL SCAPHOID (NAVICULAR)); WITH MANIPULATION, EACH BONE					
209	25650	CLOSED TREATMENT OF ULNAR STYLOID FRACTURE					
209	25660	CLOSED TREATMENT OF RADIOCARPAL OR INTERCARPAL DISLOCATION, ONE OR MORE BONES, WITH MANIPULATION					
209	25675	CLOSED TREATMENT OF DISTAL RADIOULNAR DISLOCATION WITH MANIPULATION					
209	25680	CLOSED TREATMENT OF TRANS-SCAPHOPERILUNAR TYPE OF FRACTURE DISLOCATION, WITH MANIPULATION					
209	25690	CLOSED TREATMENT OF LUNATE DISLOCATION, WITH MANIPULATION					
209	25999	UNLISTED PROCEDURE, FOREARM OR WRIST					
209	26600	CLOSED TREATMENT OF METACARPAL FRACTURE, SINGLE; WITHOUT MANIPULATION, EACH BONE					
209	26605	CLOSED TREATMENT OF METACARPAL FRACTURE, SINGLE; WITH MANIPULATION, EACH BONE					
209	26607	CLOSED TREATMENT OF METACARPAL FRACTURE, WITH MANIPULATION, WITH INTERNAL OR EXTERNAL FIXATION, EACH BONE					
209	26641	CLOSED TREATMENT OF CARPOMETACARPAL DISLOCATION, THUMB, WITH MANIPULATION					
209	26645	CLOSED TREATMENT OF CARPOMETACARPAL FRACTURE DISLOCATION, THUMB (BENNETT FRACTURE), WITH MANIPULATION					
209	26670	CLOSED TREATMENT OF CARPOMETACARPAL DISLOCATION, OTHER THAN THUMB (BENNETT FRACTURE), SINGLE, WITH MANIPULATION; WITHOUT ANESTHESIA					

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
209	26706	PERCUTANEOUS SKELETAL FIXATION OF METACARPOPHALANGEAL DISLOCATION, SINGLE, WITH MANIPULATION					
209	26742	CLOSED TREATMENT OF ARTICULAR FRACTURE, INVOLVING METACARPOPHALANGEAL OR INTERPHALANGEAL JOINT; WITH MANIPULATION, EACH					
209	27193	CLOSED TREATMENT OF PELVIC RING FRACTURE, DISLOCATION, DIASTASIS OR SUBLUXATION; WITHOUT MANIPULATION					
209	27220	CLOSED TREATMENT OF ACETABULUM (HIP SOCKET) FRACTURE(S); WITHOUT MANIPULATION					
209	27230	CLOSED TREATMENT OF FEMORAL FRACTURE, PROXIMAL END, NECK; WITHOUT MANIPULATION					
209	27238	CLOSED TREATMENT OF INTERTROCHANTERIC, PERTROCHANTERIC, OR SUBTROCHANTERIC FEMORAL FRACTURE; WITHOUT MANIPULATION					
209	27246	CLOSED TREATMENT OF GREATER TROCHANTERIC FRACTURE, WITHOUT MANIPULATION					
209	27250	CLOSED TREATMENT OF HIP DISLOCATION, TRAUMATIC; WITHOUT ANESTHESIA					
209	27256	TREATMENT OF SPONTANEOUS HIP DISLOCATION (DEVELOPMENTAL, INCLUDING CONGENITAL OR PATHOLOGICAL), BY ABDUCTION, SPLINT OR TRACTION; WITHOUT ANESTHESIA, WITHOUT MANIPULATION					
209	27265	CLOSED TREATMENT OF POST HIP ARTHROPLASTY DISLOCATION; WITHOUT ANESTHESIA					
209	27500	CLOSED TREATMENT OF FEMORAL SHAFT FRACTURE, WITHOUT MANIPULATION					
209	27501	CLOSED TREATMENT OF SUPRACONDYLAR OR TRANSCONDYLAR FEMORAL FRACTURE WITH OR WITHOUT INTERCONDYLAR EXTENSION, WITHOUT MANIPULATION					
209	27502	CLOSED TREATMENT OF FEMORAL SHAFT FRACTURE, WITH MANIPULATION, WITH OR WITHOUT SKIN OR SKELETAL TRACTION					
209	27503	CLOSED TREATMENT OF SUPRACONDYLAR OR TRANSCONDYLAR FEMORAL FRACTURE WITH OR WITHOUT INTERCONDYLAR EXTENSION, WITH MANIPULATION, WITH OR WITHOUT SKIN OR SKELETAL TRACTION					
209	27508	CLOSED TREATMENT OF FEMORAL FRACTURE, DISTAL END, MEDIAL OR LATERAL CONDYLE, WITHOUT MANIPULATION					
209	27510	CLOSED TREATMENT OF FEMORAL FRACTURE, DISTAL END, MEDIAL OR LATERAL CONDYLE, WITH MANIPULATION					
209	27516	CLOSED TREATMENT OF DISTAL FEMORAL EPIPHYSEAL SEPARATION; WITHOUT MANIPULATION					
209	27517	CLOSED TREATMENT OF DISTAL FEMORAL EPIPHYSEAL SEPARATION; WITH MANIPULATION, WITH OR WITHOUT SKIN OR SKELETAL TRACTION					
209	27520	CLOSED TREATMENT OF PATELLAR FRACTURE, WITHOUT MANIPULATION					
209	27530	CLOSED TREATMENT OF TIBIAL FRACTURE, PROXIMAL (PLATEAU); WITHOUT MANIPULATION					
209	27532	CLOSED TREATMENT OF TIBIAL FRACTURE, PROXIMAL (PLATEAU); WITH OR WITHOUT MANIPULATION, WITH SKELETAL TRACTION					
209	27538	CLOSED TREATMENT OF INTERCONDYLAR SPINE(S) AND/OR TUBEROSITY FRACTURE(S) OF KNEE, WITH OR WITHOUT MANIPULATION					
209	27550	CLOSED TREATMENT OF KNEE DISLOCATION; WITHOUT ANESTHESIA					
209	27560	CLOSED TREATMENT OF PATELLAR DISLOCATION; WITHOUT ANESTHESIA					
209	27599	UNLISTED PROCEDURE, FEMUR OR KNEE					
209	27750	CLOSED TREATMENT OF TIBIAL SHAFT FRACTURE (WITH OR WITHOUT FIBULAR FRACTURE); WITHOUT MANIPULATION					
209	27752	CLOSED TREATMENT OF TIBIAL SHAFT FRACTURE (WITH OR WITHOUT FIBULAR FRACTURE); WITH MANIPULATION, WITH OR WITHOUT SKELETAL TRACTION					
209	27760	CLOSED TREATMENT OF MEDIAL MALLEOLUS FRACTURE; WITHOUT MANIPULATION					
209	27762	CLOSED TREATMENT OF MEDIAL MALLEOLUS FRACTURE; WITH MANIPULATION, WITH OR WITHOUT SKIN OR SKELETAL TRACTION					
209	27780	CLOSED TREATMENT OF PROXIMAL FIBULA OR SHAFT FRACTURE; WITHOUT MANIPULATION					
209	27781	CLOSED TREATMENT OF PROXIMAL FIBULA OR SHAFT FRACTURE; WITH MANIPULATION					
209	27786	CLOSED TREATMENT OF DISTAL FIBULAR FRACTURE (LATERAL MALLEOLUS); WITHOUT MANIPULATION					
209	27788	CLOSED TREATMENT OF DISTAL FIBULAR FRACTURE (LATERAL MALLEOLUS); WITH MANIPULATION					
209	27808	CLOSED TREATMENT OF BIMALLEOLAR ANKLE FRACTURE, (INCLUDING POTTS); WITHOUT MANIPULATION					
209	27810	CLOSED TREATMENT OF BIMALLEOLAR ANKLE FRACTURE, (INCLUDING POTTS); WITH MANIPULATION					
209	27816	CLOSED TREATMENT OF TRIMALLEOLAR ANKLE FRACTURE; WITHOUT MANIPULATION					
209	27818	CLOSED TREATMENT OF TRIMALLEOLAR ANKLE FRACTURE; WITH MANIPULATION					
209	27824	CLOSED TREATMENT OF FRACTURE OF WEIGHT BEARING ARTICULAR PORTION OF DISTAL TIBIA (EG, PILON OR TIBIAL PLAFOND), WITH OR WITHOUT ANESTHESIA; WITHOUT MANIPULATION					
209	27825	CLOSED TREATMENT OF FRACTURE OF WEIGHT BEARING ARTICULAR PORTION OF DISTAL TIBIA (EG, PILON OR TIBIAL PLAFOND), WITH OR WITHOUT ANESTHESIA; WITH SKELETAL TRACTION AND/OR REQUIRING MANIPULATION					
209	27830	CLOSED TREATMENT OF PROXIMAL TIBIOFIBULAR JOINT DISLOCATION; WITHOUT ANESTHESIA					
209	27840	CLOSED TREATMENT OF ANKLE DISLOCATION; WITHOUT ANESTHESIA					
209	27899	UNLISTED PROCEDURE, LEG OR ANKLE					
209	28400	CLOSED TREATMENT OF CALCANEAL FRACTURE; WITHOUT MANIPULATION					
209	28405	CLOSED TREATMENT OF CALCANEAL FRACTURE; WITH MANIPULATION					
209	28430	CLOSED TREATMENT OF TALUS FRACTURE; WITHOUT MANIPULATION					
209	28435	CLOSED TREATMENT OF TALUS FRACTURE; WITH MANIPULATION					
209	28450	TREATMENT OF TARSAL BONE FRACTURE (EXCEPT TALUS AND CALCANEUS); WITHOUT MANIPULATION, EACH					
209	28455	TREATMENT OF TARSAL BONE FRACTURE (EXCEPT TALUS AND CALCANEUS); WITH MANIPULATION, EACH					
209	28470	CLOSED TREATMENT OF METATARSAL FRACTURE; WITHOUT MANIPULATION, EACH					
209	28475	CLOSED TREATMENT OF METATARSAL FRACTURE; WITH MANIPULATION, EACH					
209	28530	CLOSED TREATMENT OF SESAMOID FRACTURE					
209	28540	CLOSED TREATMENT OF TARSAL BONE DISLOCATION, OTHER THAN TALOTARSAL; WITHOUT ANESTHESIA					
209	28570	CLOSED TREATMENT OF TALOTARSAL JOINT DISLOCATION; WITHOUT ANESTHESIA					
209	28600	CLOSED TREATMENT OF TARSOMETATARSAL JOINT DISLOCATION; WITHOUT ANESTHESIA					
209	31586	TREATMENT OF CLOSED LARYNGEAL FRACTURE; WITH CLOSED MANIPULATIVE REDUCTION					
210	Bone/joint manipulation under anesthesia		T	10.46	$530.00	$283.40	$106.00
210	22505	MANIPULATION OF SPINE REQUIRING ANESTHESIA, ANY REGION					
210	23655	CLOSED TREATMENT OF SHOULDER DISLOCATION, WITH MANIPULATION; REQUIRING ANESTHESIA					
210	23700	MANIPULATION UNDER ANESTHESIA, SHOULDER JOINT, INCLUDING APPLICATION OF FIXATION APPARATUS (DISLOCATION EXCLUDED)					
210	24605	TREATMENT OF CLOSED ELBOW DISLOCATION; REQUIRING ANESTHESIA					
210	26675	CLOSED TREATMENT OF CARPOMETACARPAL DISLOCATION, OTHER THAN THUMB (BENNETT FRACTURE), SINGLE, WITH MANIPULATION; REQUIRING ANESTHESIA					
210	26705	CLOSED TREATMENT OF METACARPOPHALANGEAL DISLOCATION, SINGLE, WITH MANIPULATION; REQUIRING ANESTHESIA					
210	26775	CLOSED TREATMENT OF INTERPHALANGEAL JOINT DISLOCATION, SINGLE, WITH MANIPULATION; REQUIRING ANESTHESIA					

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
210	27194	CLOSED TREATMENT OF PELVIC RING FRACTURE, DISLOCATION, DIASTASIS OR SUBLUXATION; WITH MANIPULATION, REQUIRING MORE THAN LOCAL ANESTHESIA					
210	27252	CLOSED TREATMENT OF HIP DISLOCATION, TRAUMATIC; REQUIRING ANESTHESIA					
210	27257	TREATMENT OF SPONTANEOUS HIP DISLOCATION (DEVELOPMENTAL, INCLUDING CONGENITAL OR PATHOLOGICAL), BY ABDUCTION, SPLINT OR TRACTION; WITH MANIPULATION, REQUIRING ANESTHESIA					
210	27275	MANIPULATION, HIP JOINT, REQUIRING GENERAL ANESTHESIA					
210	27552	CLOSED TREATMENT OF KNEE DISLOCATION; REQUIRING ANESTHESIA					
210	27562	CLOSED TREATMENT OF PATELLAR DISLOCATION; REQUIRING ANESTHESIA					
210	27570	MANIPULATION OF KNEE JOINT UNDER GENERAL ANESTHESIA (INCLUDES APPLICATION OF TRACTION OR OTHER FIXATION DEVICES)					
210	27831	CLOSED TREATMENT OF PROXIMAL TIBIOFIBULAR JOINT DISLOCATION; REQUIRING ANESTHESIA					
210	27842	CLOSED TREATMENT OF ANKLE DISLOCATION; REQUIRING ANESTHESIA, WITH OR WITHOUT PERCUTANEOUS SKELETAL FIXATION					
210	27860	MANIPULATION OF ANKLE UNDER GENERAL ANESTHESIA (INCLUDES APPLICATION OF TRACTION OR OTHER FIXATION APPARATUS)					
210	28545	CLOSED TREATMENT OF TARSAL BONE DISLOCATION, OTHER THAN TALOTARSAL; REQUIRING ANESTHESIA					
210	28575	CLOSED TREATMENT OF TALOTARSAL JOINT DISLOCATION; REQUIRING ANESTHESIA					
210	28605	CLOSED TREATMENT OF TARSOMETATARSAL JOINT DISLOCATION; REQUIRING ANESTHESIA					
210	28635	CLOSED TREATMENT OF METATARSOPHALANGEAL JOINT DISLOCATION; REQUIRING ANESTHESIA					
210	28665	CLOSED TREATMENT OF INTERPHALANGEAL JOINT DISLOCATION; REQUIRING ANESTHESIA					
216	Open/percutaneous treatment fracture or dislocation		T	20.13	$1,019.98	$520.82	$204.00
216	21336	OPEN TREATMENT OF NASAL SEPTAL FRACTURE, WITH OR WITHOUT STABILIZATION					
216	21805	OPEN TREATMENT OF RIB FRACTURE WITHOUT FIXATION, EACH					
216	23515	OPEN TREATMENT OF CLAVICULAR FRACTURE, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
216	23530	OPEN TREATMENT OF STERNOCLAVICULAR DISLOCATION, ACUTE OR CHRONIC;					
216	23532	OPEN TREATMENT OF STERNOCLAVICULAR DISLOCATION, ACUTE OR CHRONIC; WITH FASCIAL GRAFT (INCLUDES OBTAINING GRAFT)					
216	23550	OPEN TREATMENT OF ACROMIOCLAVICULAR DISLOCATION, ACUTE OR CHRONIC;					
216	23552	OPEN TREATMENT OF ACROMIOCLAVICULAR DISLOCATION, ACUTE OR CHRONIC; WITH FASCIAL GRAFT (INCLUDES OBTAINING GRAFT)					
216	23585	OPEN TREATMENT OF SCAPULAR FRACTURE (BODY, GLENOID OR ACROMION) WITH OR WITHOUT INTERNAL FIXATION					
216	23615	OPEN TREATMENT OF PROXIMAL HUMERAL (SURGICAL OR ANATOMICAL NECK) FRACTURE, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION, WITH OR WITHOUT REPAIR OF TUBEROSITY(-IES);					
216	23616	OPEN TREATMENT OF PROXIMAL HUMERAL (SURGICAL OR ANATOMICAL NECK) FRACTURE, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION, WITH OR WITHOUT REPAIR OF TUBEROSITY(-IES); WITH PROXIMAL HUMERAL PROSTHETIC REPLACEMENT					
216	23630	OPEN TREATMENT OF GREATER TUBEROSITY FRACTURE, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
216	23660	OPEN TREATMENT OF ACUTE SHOULDER DISLOCATION					
216	23670	OPEN TREATMENT OF SHOULDER DISLOCATION, WITH FRACTURE OF GREATER TUBEROSITY, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
216	23680	OPEN TREATMENT OF SHOULDER DISLOCATION, WITH SURGICAL OR ANATOMICAL NECK FRACTURE, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
216	24515	OPEN TREATMENT OF HUMERAL SHAFT FRACTURE WITH PLATE/SCREWS, WITH OR WITHOUT CERCLAGE					
216	24516	OPEN TREATMENT OF HUMERAL SHAFT FRACTURE, WITH INSERTION OF INTRAMEDULLARY IMPLANT, WITH OR WITHOUT CERCLAGE AND/OR LOCKING SCREWS					
216	24538	PERCUTANEOUS SKELETAL FIXATION OF SUPRACONDYLAR OR TRANSCONDYLAR HUMERAL FRACTURE, WITH OR WITHOUT INTERCONDYLAR EXTENSION					
216	24545	OPEN TREATMENT OF HUMERAL SUPRACONDYLAR OR TRANSCONDYLAR FRACTURE, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION; WITHOUT INTERCONDYLAR EXTENSION					
216	24546	OPEN TREATMENT OF HUMERAL SUPRACONDYLAR OR TRANSCONDYLAR FRACTURE, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION; WITH INTERCONDYLAR EXTENSION					
216	24566	PERCUTANEOUS SKELETAL FIXATION OF HUMERAL EPICONDYLAR FRACTURE, MEDIAL OR LATERAL, WITH MANIPULATION					
216	24575	OPEN TREATMENT OF HUMERAL EPICONDYLAR FRACTURE, MEDIAL OR LATERAL, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
216	24579	OPEN TREATMENT OF HUMERAL CONDYLAR FRACTURE, MEDIAL OR LATERAL, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
216	24582	PERCUTANEOUS SKELETAL FIXATION OF HUMERAL CONDYLAR FRACTURE, MEDIAL OR LATERAL, WITH MANIPULATION					
216	24586	OPEN TREATMENT OF PERIARTICULAR FRACTURE AND/OR DISLOCATION OF THE ELBOW (FRACTURE DISTAL HUMERUS AND PROXIMAL ULNA AND/ OR PROXIMAL RADIUS);					
216	24587	OPEN TREATMENT OF PERIARTICULAR FRACTURE AND/OR DISLOCATION OF THE ELBOW (FRACTURE DISTAL HUMERUS AND PROXIMAL ULNA AND/ OR PROXIMAL RADIUS); WITH IMPLANT ARTHROPLASTY					
216	24615	OPEN TREATMENT OF ACUTE OR CHRONIC ELBOW DISLOCATION					
216	24635	OPEN TREATMENT OF MONTEGGIA TYPE OF FRACTURE DISLOCATION AT ELBOW (FRACTURE PROXIMAL END OF ULNA WITH DISLOCATION OF RADIAL HEAD), WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
216	24665	OPEN TREATMENT OF RADIAL HEAD OR NECK FRACTURE, WITH OR WITHOUT INTERNAL FIXATION OR RADIAL HEAD EXCISION;					
216	24666	OPEN TREATMENT OF RADIAL HEAD OR NECK FRACTURE, WITH OR WITHOUT INTERNAL FIXATION OR RADIAL HEAD EXCISION; WITH RADIAL HEAD PROSTHETIC REPLACEMENT					
216	24685	OPEN TREATMENT OF ULNAR FRACTURE PROXIMAL END (OLECRANON PROCESS), WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
216	25515	OPEN TREATMENT OF RADIAL SHAFT FRACTURE, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
216	25525	OPEN TREATMENT OF RADIAL SHAFT FRACTURE, WITH INTERNAL AND/ OR EXTERNAL FIXATION AND CLOSED TREATMENT OF DISLOCATION OF DISTAL RADIO-ULNAR JOINT (GALEAZZI FRACTURE/DISLOCATION), WITH OR WITHOUT PERCUTANEOUS SKELETAL FIXATION					
216	25526	OPEN TREATMENT OF RADIAL SHAFT FRACTURE, WITH INTERNAL AND/ OR EXTERNAL FIXATION AND OPEN TREATMENT, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION OF DISTAL RADIO-ULNAR JOINT (GALEAZZI FRACTURE/DISLOCATION), INCLUDES REPAIR OF TRIANGULAR CARTILAGE					
216	25545	OPEN TREATMENT OF ULNAR SHAFT FRACTURE, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
216	25574	OPEN TREATMENT OF RADIAL AND ULNAR SHAFT FRACTURES, WITH INTERNAL OR EXTERNAL FIXATION; OF RADIUS OR ULNA					

(See Addendum D. for Payment of Medical Visits)

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
216	25575	OPEN TREATMENT OF RADIAL AND ULNAR SHAFT FRACTURES, WITH INTERNAL OR EXTERNAL FIXATION; OF RADIUS AND ULNA					
216	25611	PERCUTANEOUS SKELETAL FIXATION OF DISTAL RADIAL FRACTURE (EG, COLLES OR SMITH TYPE) OR EPIPHYSEAL SEPARATION, WITH OR WITHOUT FRACTURE OF ULNAR STYLOID, REQUIRING MANIPULATION, WITH OR WITHOUT EXTERNAL FIXATION					
216	25620	OPEN TREATMENT OF DISTAL RADIAL FRACTURE (EG, COLLES OR SMITH TYPE) OR EPIPHYSEAL SEPARATION, WITH OR WITHOUT FRACTURE OF ULNAR STYLOID, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
216	25628	OPEN TREATMENT OF CARPAL SCAPHOID (NAVICULAR) FRACTURE, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
216	25645	OPEN TREATMENT OF CARPAL BONE FRACTURE (EXCLUDING CARPAL SCAPHOID (NAVICULAR)), EACH BONE					
216	25670	OPEN TREATMENT OF RADIOCARPAL OR INTERCARPAL DISLOCATION, ONE OR MORE BONES					
216	25676	OPEN TREATMENT OF DISTAL RADIOULNAR DISLOCATION, ACUTE OR CHRONIC					
216	25685	OPEN TREATMENT OF TRANS-SCAPHOPERILUNAR TYPE OF FRACTURE DISLOCATION					
216	25695	OPEN TREATMENT OF LUNATE DISLOCATION					
216	26608	PERCUTANEOUS SKELETAL FIXATION OF METACARPAL FRACTURE, EACH BONE					
216	26615	OPEN TREATMENT OF METACARPAL FRACTURE, SINGLE, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION, EACH BONE					
216	26650	PERCUTANEOUS SKELETAL FIXATION OF CARPOMETACARPAL FRACTURE DISLOCATION, THUMB (BENNETT FRACTURE), WITH MANIPULATION, WITH OR WITHOUT EXTERNAL FIXATION					
216	26665	OPEN TREATMENT OF CARPOMETACARPAL FRACTURE DISLOCATION, THUMB (BENNETT FRACTURE), WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
216	26676	PERCUTANEOUS SKELETAL FIXATION OF CARPOMETACARPAL DISLOCATION, OTHER THAN THUMB (BENNETT FRACTURE), SINGLE, WITH MANIPULATION					
216	26685	OPEN TREATMENT OF CARPOMETACARPAL DISLOCATION, OTHER THAN THUMB (BENNETT FRACTURE); SINGLE, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
216	26686	OPEN TREATMENT OF CARPOMETACARPAL DISLOCATION, OTHER THAN THUMB (BENNETT FRACTURE); COMPLEX, MULTIPLE OR DELAYED REDUCTION					
216	26715	OPEN TREATMENT OF METACARPOPHALANGEAL DISLOCATION, SINGLE, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
216	26727	PERCUTANEOUS SKELETAL FIXATION OF UNSTABLE PHALANGEAL SHAFT FRACTURE, PROXIMAL OR MIDDLE PHALANX, FINGER OR THUMB, WITH MANIPULATION, EACH					
216	26735	OPEN TREATMENT OF PHALANGEAL SHAFT FRACTURE, PROXIMAL OR MIDDLE PHALANX, FINGER OR THUMB, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION, EACH					
216	26746	OPEN TREATMENT OF ARTICULAR FRACTURE, INVOLVING METACARPOPHALANGEAL OR INTERPHALANGEAL JOINT, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION, EACH					
216	26756	PERCUTANEOUS SKELETAL FIXATION OF DISTAL PHALANGEAL FRACTURE, FINGER OR THUMB, EACH					
216	26765	OPEN TREATMENT OF DISTAL PHALANGEAL FRACTURE, FINGER OR THUMB, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION, EACH					
216	26776	PERCUTANEOUS SKELETAL FIXATION OF INTERPHALANGEAL JOINT DISLOCATION, SINGLE, WITH MANIPULATION					
216	26785	OPEN TREATMENT OF INTERPHALANGEAL JOINT DISLOCATION, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION, SINGLE					
216	27202	OPEN TREATMENT OF COCCYGEAL FRACTURE					
216	27509	PERCUTANEOUS SKELETAL FIXATION OF FEMORAL FRACTURE, DISTAL END, MEDIAL OR LATERAL CONDYLE, OR SUPRACONDYLAR OR TRANSCONDYLAR, WITH OR WITHOUT INTERCONDYLAR EXTENSION, OR DISTAL FEMORAL EPIPHYSEAL SEPARATION					
216	27556	OPEN TREATMENT OF KNEE DISLOCATION, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION; WITHOUT PRIMARY LIGAMENTOUS REPAIR OR AUGMENTATION/RECONSTRUCTION					
216	27566	OPEN TREATMENT OF PATELLAR DISLOCATION, WITH OR WITHOUT PARTIAL OR TOTAL PATELLECTOMY					
216	27615	RADICAL RESECTION OF TUMOR (EG, MALIGNANT NEOPLASM), SOFT TISSUE OF LEG OR ANKLE AREA					
216	27756	PERCUTANEOUS SKELETAL FIXATION OF TIBIAL SHAFT FRACTURE (WITH OR WITHOUT FIBULAR FRACTURE) (EG, PINS OR SCREWS)					
216	27758	OPEN TREATMENT OF TIBIAL SHAFT FRACTURE, (WITH OR WITHOUT FIBULAR FRACTURE) WITH PLATE/SCREWS, WITH OR WITHOUT CERCLAGE					
216	27759	OPEN TREATMENT OF TIBIAL SHAFT FRACTURE (WITH OR WITHOUT FIBULAR FRACTURE) BY INTRAMEDULLARY IMPLANT, WITH OR WITHOUT INTERLOCKING SCREWS AND/OR CERCLAGE					
216	27766	OPEN TREATMENT OF MEDIAL MALLEOLUS FRACTURE, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
216	27784	OPEN TREATMENT OF PROXIMAL FIBULA OR SHAFT FRACTURE, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
216	27792	OPEN TREATMENT OF DISTAL FIBULAR FRACTURE (LATERAL MALLEOLUS), WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
216	27814	OPEN TREATMENT OF BIMALLEOLAR ANKLE FRACTURE, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
216	27822	OPEN TREATMENT OF TRIMALLEOLAR ANKLE FRACTURE, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION, MEDIAL AND/OR LATERAL MALLEOLUS; WITHOUT FIXATION OF POSTERIOR LIP					
216	27823	OPEN TREATMENT OF TRIMALLEOLAR ANKLE FRACTURE, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION, MEDIAL AND/OR LATERAL MALLEOLUS; WITH FIXATION OF POSTERIOR LIP					
216	27826	OPEN TREATMENT OF FRACTURE OF WEIGHT BEARING ARTICULAR SURFACE/ PORTION OF DISTAL TIBIA (EG, PILON OR TIBIAL PLAFOND), WITH INTERNAL OR EXTERNAL FIXATION; OF FIBULA ONLY					
216	27827	OPEN TREATMENT OF FRACTURE OF WEIGHT BEARING ARTICULAR SURFACE/ PORTION OF DISTAL TIBIA (EG, PILON OR TIBIAL PLAFOND), WITH INTERNAL OR EXTERNAL FIXATION; OF TIBIA ONLY					
216	27828	OPEN TREATMENT OF FRACTURE OF WEIGHT BEARING ARTICULAR SURFACE/ PORTION OF DISTAL TIBIA (EG, PILON OR TIBIAL PLAFOND), WITH INTERNAL OR EXTERNAL FIXATION; OF BOTH TIBIA AND FIBULA					
216	27829	OPEN TREATMENT OF DISTAL TIBIOFIBULAR JOINT (SYNDESMOSIS) DISRUPTION, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
216	27832	OPEN TREATMENT OF PROXIMAL TIBIOFIBULAR JOINT DISLOCATION, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION, OR WITH EXCISION OF PROXIMAL FIBULA					
216	27846	OPEN TREATMENT OF ANKLE DISLOCATION, WITH OR WITHOUT PERCUTANEOUS SKELETAL FIXATION; WITHOUT REPAIR OR INTERNAL FIXATION					
216	27848	OPEN TREATMENT OF ANKLE DISLOCATION, WITH OR WITHOUT PERCUTANEOUS SKELETAL FIXATION; WITH REPAIR OR INTERNAL OR EXTERNAL FIXATION					
216	28406	PERCUTANEOUS SKELETAL FIXATION OF CALCANEAL FRACTURE, WITH MANIPULATION					
216	28415	OPEN TREATMENT OF CALCANEAL FRACTURE, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION;					
216	28420	OPEN TREATMENT OF CALCANEAL FRACTURE, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION; WITH PRIMARY ILIAC OR OTHER AUTOGENOUS BONE GRAFT (INCLUDES OBTAINING GRAFT)					
216	28436	PERCUTANEOUS SKELETAL FIXATION OF TALUS FRACTURE, WITH MANIPULATION					
216	28445	OPEN TREATMENT OF TALUS FRACTURE, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
216	28456	PERCUTANEOUS SKELETAL FIXATION OF TARSAL BONE FRACTURE (EXCEPT TALUS AND CALCANEUS), WITH MANIPULATION, EACH					

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
216	28465	OPEN TREATMENT OF TARSAL BONE FRACTURE (EXCEPT TALUS AND CALCANEUS), WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION, EACH					
216	28476	PERCUTANEOUS SKELETAL FIXATION OF METATARSAL FRACTURE, WITH MANIPULATION, EACH					
216	28485	OPEN TREATMENT OF METATARSAL FRACTURE, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION, EACH					
216	28496	PERCUTANEOUS SKELETAL FIXATION OF FRACTURE GREAT TOE, PHALANX OR PHALANGES, WITH MANIPULATION					
216	28505	OPEN TREATMENT OF FRACTURE GREAT TOE, PHALANX OR PHALANGES, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
216	28525	OPEN TREATMENT OF FRACTURE, PHALANX OR PHALANGES, OTHER THAN GREAT TOE, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION, EACH					
216	28531	OPEN TREATMENT OF SESAMOID FRACTURE, WITH OR WITHOUT INTERNAL FIXATION					
216	28546	PERCUTANEOUS SKELETAL FIXATION OF TARSAL BONE DISLOCATION, OTHER THAN TALOTARSAL, WITH MANIPULATION					
216	28555	OPEN TREATMENT OF TARSAL BONE DISLOCATION, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
216	28576	PERCUTANEOUS SKELETAL FIXATION OF TALOTARSAL JOINT DISLOCATION, WITH MANIPULATION					
216	28585	OPEN TREATMENT OF TALOTARSAL JOINT DISLOCATION, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
216	28606	PERCUTANEOUS SKELETAL FIXATION OF TARSOMETATARSAL JOINT DISLOCATION, WITH MANIPULATION					
216	28615	OPEN TREATMENT OF TARSOMETATARSAL JOINT DISLOCATION, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
216	28636	PERCUTANEOUS SKELETAL FIXATION OF METATARSOPHALANGEAL JOINT DISLOCATION, WITH MANIPULATION					
216	28645	OPEN TREATMENT OF METATARSOPHALANGEAL JOINT DISLOCATION, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
216	28666	PERCUTANEOUS SKELETAL FIXATION OF INTERPHALANGEAL JOINT DISLOCATION, WITH MANIPULATION					
216	28675	OPEN TREATMENT OF INTERPHALANGEAL JOINT DISLOCATION, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION					
217	Arthroplasty		T	20.48	$1,037.71	$526.81	$207.54
217	24360	ARTHROPLASTY, ELBOW; WITH MEMBRANE					
217	24365	ARTHROPLASTY, RADIAL HEAD;					
217	25332	ARTHROPLASTY, WRIST, WITH OR WITHOUT INTERPOSITION, WITH OR WITHOUT EXTERNAL OR INTERNAL FIXATION					
217	25447	INTERPOSITION ARTHROPLASTY, INTERCARPAL OR CARPOMETACARPAL JOINTS					
217	25449	REVISION OF ARTHROPLASTY, INCLUDING REMOVAL OF IMPLANT, WRIST JOINT					
217	26530	ARTHROPLASTY, METACARPOPHALANGEAL JOINT; SINGLE, EACH					
217	26535	ARTHROPLASTY INTERPHALANGEAL JOINT; SINGLE, EACH					
217	27266	CLOSED TREATMENT OF POST HIP ARTHROPLASTY DISLOCATION; REQUIRING REGIONAL OR GENERAL ANESTHESIA					
217	27437	ARTHROPLASTY, PATELLA; WITHOUT PROSTHESIS					
217	27440	ARTHROPLASTY, KNEE, TIBIAL PLATEAU;					
217	27441	ARTHROPLASTY, KNEE, TIBIAL PLATEAU; WITH DEBRIDEMENT AND PARTIAL SYNOVECTOMY					
217	27442	ARTHROPLASTY, KNEE, FEMORAL CONDYLES OR TIBIAL PLATEAUS;					
217	27443	ARTHROPLASTY, KNEE, FEMORAL CONDYLES OR TIBIAL PLATEAUS; WITH DEBRIDEMENT AND PARTIAL SYNOVECTOMY					
217	27700	ARTHROPLASTY, ANKLE;					
218	Arthroplasty with prosthesis		T	27.49	$1,392.90	$715.52	$278.58
218	21243	ARTHROPLASTY, TEMPOROMANDIBULAR JOINT, WITH PROSTHETIC JOINT REPLACEMENT					
218	24361	ARTHROPLASTY, ELBOW; WITH DISTAL HUMERAL PROSTHETIC REPLACEMENT					
218	24362	ARTHROPLASTY, ELBOW; WITH IMPLANT AND FASCIA LATA LIGAMENT RECONSTRUCTION					
218	24363	ARTHROPLASTY, ELBOW; WITH DISTAL HUMERUS AND PROXIMAL ULNAR PROSTHETIC REPLACEMENT (''TOTAL ELBOW'')					
218	24366	ARTHROPLASTY, RADIAL HEAD; WITH IMPLANT					
218	25441	ARTHROPLASTY WITH PROSTHETIC REPLACEMENT; DISTAL RADIUS					
218	25442	ARTHROPLASTY WITH PROSTHETIC REPLACEMENT; DISTAL ULNA					
218	25443	ARTHROPLASTY WITH PROSTHETIC REPLACEMENT; SCAPHOID (NAVICULAR)					
218	25444	ARTHROPLASTY WITH PROSTHETIC REPLACEMENT; LUNATE					
218	25445	ARTHROPLASTY WITH PROSTHETIC REPLACEMENT; TRAPEZIUM					
218	25446	ARTHROPLASTY WITH PROSTHETIC REPLACEMENT; DISTAL RADIUS AND PARTIAL OR ENTIRE CARPUS (''TOTAL WRIST'')					
218	26531	ARTHROPLASTY, METACARPOPHALANGEAL JOINT; WITH PROSTHETIC IMPLANT, SINGLE, EACH					
218	26536	ARTHROPLASTY INTERPHALANGEAL JOINT; WITH PROSTHETIC IMPLANT, SINGLE, EACH					
218	27438	ARTHROPLASTY, PATELLA; WITH PROSTHESIS					
226	Maxillofacial prostheses		T	1.59	$80.56	$21.92	$16.11
226	21076	IMPRESSION AND CUSTOM PREPARATION; SURGICAL OBTURATOR PROSTHESIS					
226	21077	IMPRESSION AND CUSTOM PREPARATION; ORBITAL PROSTHESIS					
226	21079	IMPRESSION AND CUSTOM PREPARATION; INTERIM OBTURATOR PROSTHESIS					
226	21080	IMPRESSION AND CUSTOM PREPARATION; DEFINITIVE OBTURATOR PROSTHESIS					
226	21081	IMPRESSION AND CUSTOM PREPARATION; MANDIBULAR RESECTION PROSTHESIS					
226	21082	IMPRESSION AND CUSTOM PREPARATION; PALATAL AUGMENTATION PROSTHESIS					
226	21083	IMPRESSION AND CUSTOM PREPARATION; PALATAL LIFT PROSTHESIS					
226	21084	IMPRESSION AND CUSTOM PREPARATION; SPEECH AID PROSTHESIS					
226	21086	IMPRESSION AND CUSTOM PREPARATION; AURICULAR PROSTHESIS					
226	21087	IMPRESSION AND CUSTOM PREPARATION; NASAL PROSTHESIS					
226	21088	IMPRESSION AND CUSTOM PREPARATION; FACIAL PROSTHESIS					
226	21089	UNLISTED MAXILLOFACIAL PROSTHETIC PROCEDURE					
231	Level I skull and facial bone procedures		T	12.02	$609.05	$299.9	$121.81
231	21015	RADICAL RESECTION OF TUMOR (EG, MALIGNANT NEOPLASM), SOFT TISSUE OF FACE OR SCALP					
231	21025	EXCISION OF BONE (EG, FOR OSTEOMYELITIS OR BONE ABSCESS); MANDIBLE					
231	21026	EXCISION OF BONE (EG, FOR OSTEOMYELITIS OR BONE ABSCESS); FACIAL BONE(S)					
231	21029	REMOVAL BY CONTOURING OF BENIGN TUMOR OF FACIAL BONE (EG, FIBROUS DYSPLASIA)					
231	21030	EXCISION OF BENIGN TUMOR OR CYST OF FACIAL BONE OTHER THAN MANDIBLE					
231	21031	EXCISION OF TORUS MANDIBULARIS					
231	21032	EXCISION OF MAXILLARY TORUS PALATINUS					
231	21040	EXCISION OF BENIGN CYST OR TUMOR OF MANDIBLE; SIMPLE					
231	21041	EXCISION OF BENIGN CYST OR TUMOR OF MANDIBLE; COMPLEX					
231	21100	APPLICATION OF HALO TYPE APPLIANCE FOR MAXILLOFACIAL FIXATION, INCLUDES REMOVAL (SEPARATE PROCEDURE)					

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
231	21110	APPLICATION OF INTERDENTAL FIXATION DEVICE FOR CONDITIONS OTHER THAN FRACTURE OR DISLOCATION, INCLUDES					
231	21120	GENIOPLASTY; AUGMENTATION (AUTOGRAFT, ALLOGRAFT, PROSTHETIC MATERIAL)					
231	21125	AUGMENTATION, MANDIBULAR BODY OR ANGLE; PROSTHETIC MATERIAL					
231	21280	MEDIAL CANTHOPEXY (SEPARATE PROCEDURE)					
231	21282	LATERAL CANTHOPEXY					
231	21295	REDUCTION OF MASSETER MUSCLE AND BONE (EG, FOR TREATMENT OF BENIGN MASSETERIC HYPERTROPHY); EXTRAORAL APPROACH					
231	21296	REDUCTION OF MASSETER MUSCLE AND BONE (EG, FOR TREATMENT OF BENIGN MASSETERIC HYPERTROPHY); INTRAORAL APPROACH					
231	21299	UNLISTED CRANIOFACIAL AND MAXILLOFACIAL PROCEDURE					
231	21300	CLOSED TREATMENT OF SKULL FRACTURE WITHOUT OPERATION					
231	21310	CLOSED TREATMENT OF NASAL BONE FRACTURE WITHOUT MANIPULATION					
231	21315	CLOSED TREATMENT OF NASAL BONE FRACTURE; WITHOUT STABILIZATION					
231	21320	CLOSED TREATMENT OF NASAL BONE FRACTURE; WITH STABILIZATION					
231	21325	OPEN TREATMENT OF NASAL FRACTURE; UNCOMPLICATED					
231	21337	CLOSED TREATMENT OF NASAL SEPTAL FRACTURE, WITH OR WITHOUT STABILIZATION					
231	21355	PERCUTANEOUS TREATMENT OF FRACTURE OF MALAR AREA, INCLUDING ZYGOMATIC ARCH AND MALAR TRIPOD, WITH MANIPULATION					
231	21400	CLOSED TREATMENT OF FRACTURE OF ORBIT, EXCEPT ''BLOWOUT''; WITHOUT MANIPULATION					
231	21401	CLOSED TREATMENT OF FRACTURE OF ORBIT, EXCEPT ''BLOWOUT''; WITH MANIPULATION					
231	21440	CLOSED TREATMENT OF MANDIBULAR OR MAXILLARY ALVEOLAR RIDGE FRACTURE (SEPARATE PROCEDURE)					
231	21451	CLOSED TREATMENT OF MANDIBULAR FRACTURE; WITH MANIPULATION					
231	21480	CLOSED TREATMENT OF TEMPOROMANDIBULAR DISLOCATION; INITIAL OR SUBSEQUENT					
231	21485	CLOSED TREATMENT OF TEMPOROMANDIBULAR DISLOCATION; COMPLICATED (EG, RECURRENT REQUIRING INTERMAXILLARY FIXATION OR SPLINTING), INITIAL OR SUBSEQUENT					
231	21493	CLOSED TREATMENT OF HYOID FRACTURE; WITHOUT MANIPULATION					
231	21494	CLOSED TREATMENT OF HYOID FRACTURE; WITH MANIPULATION					
231	21497	INTERDENTAL WIRING, FOR CONDITION OTHER THAN FRACTURE					
231	21499	UNLISTED MUSCULOSKELETAL PROCEDURE, HEAD					
231	41822	EXCISION OF FIBROUS TUBEROSITIES, DENTOALVEOLAR STRUCTURES					
231	41823	EXCISION OF OSSEOUS TUBEROSITIES, DENTOALVEOLAR STRUCTURES					
232	Level II skull and facial bone procedures		T	23.93	$1,212.52	$639.35	$242.50
232	21010	ARTHROTOMY, TEMPOROMANDIBULAR JOINT					
232	21034	EXCISION OF MALIGNANT TUMOR OF FACIAL BONE OTHER THAN MANDIBLE					
232	21044	EXCISION OF MALIGNANT TUMOR OF MANDIBLE					
232	21050	CONDYLECTOMY, TEMPOROMANDIBULAR JOINT (SEPARATE PROCEDURE)					
232	21060	MENISCECTOMY, PARTIAL OR COMPLETE, TEMPOROMANDIBULAR JOINT (SEPARATE PROCEDURE)					
232	21070	CORONOIDECTOMY (SEPARATE PROCEDURE)					
232	21121	GENIOPLASTY; SLIDING OSTEOTOMY, SINGLE PIECE					
232	21122	GENIOPLASTY; SLIDING OSTEOTOMIES, TWO OR MORE OSTEOTOMIES (EG, WEDGE EXCISION OR BONE WEDGE REVERSAL FOR ASYMMETRICAL CHIN)					
232	21123	GENIOPLASTY; SLIDING, AUGMENTATION WITH INTERPOSITIONAL BONE GRAFTS (INCLUDES OBTAINING AUTOGRAFTS)					
232	21127	AUGMENTATION, MANDIBULAR BODY OR ANGLE; WITH BONE GRAFT, ONLAY OR INTERPOSITIONAL (INCLUDES OBTAINING AUTOGRAFT)					
232	21181	RECONSTRUCTION BY CONTOURING OF BENIGN TUMOR OF CRANIAL BONES (EG, FIBROUS DYSPLASIA), EXTRACRANIAL					
232	21206	OSTEOTOMY, MAXILLA, SEGMENTAL (EG, WASSMUND OR SCHUCHARD)					
232	21208	OSTEOPLASTY, FACIAL BONES; AUGMENTATION (AUTOGRAFT, ALLOGRAFT, OR PROSTHETIC IMPLANT)					
232	21209	OSTEOPLASTY, FACIAL BONES; REDUCTION					
232	21210	GRAFT, BONE; NASAL, MAXILLARY OR MALAR AREAS (INCLUDES OBTAINING GRAFT)					
232	21215	GRAFT, BONE; MANDIBLE (INCLUDES OBTAINING GRAFT)					
232	21230	GRAFT; RIB CARTILAGE, AUTOGENOUS, TO FACE, CHIN, NOSE OR EAR (INCLUDES OBTAINING GRAFT)					
232	21235	GRAFT; EAR CARTILAGE, AUTOGENOUS, TO NOSE OR EAR (INCLUDES OBTAINING GRAFT)					
232	21240	ARTHROPLASTY, TEMPOROMANDIBULAR JOINT, WITH OR WITHOUT AUTOGRAFT (INCLUDES OBTAINING GRAFT)					
232	21242	ARTHROPLASTY, TEMPOROMANDIBULAR JOINT, WITH ALLOGRAFT					
232	21244	RECONSTRUCTION OF MANDIBLE, EXTRAORAL, WITH TRANSOSTEAL BONE PLATE (EG, MANDIBULAR STAPLE BONE PLATE)					
232	21245	RECONSTRUCTION OF MANDIBLE OR MAXILLA, SUBPERIOSTEAL IMPLANT; PARTIAL					
232	21246	RECONSTRUCTION OF MANDIBLE OR MAXILLA, SUBPERIOSTEAL IMPLANT; COMPLETE					
232	21248	RECONSTRUCTION OF MANDIBLE OR MAXILLA, ENDOSTEAL IMPLANT (EG, BLADE, CYLINDER); PARTIAL					
232	21249	RECONSTRUCTION OF MANDIBLE OR MAXILLA, ENDOSTEAL IMPLANT (EG, BLADE, CYLINDER); COMPLETE					
232	21260	PERIORBITAL OSTEOTOMIES FOR ORBITAL HYPERTELORISM, WITH BONE GRAFTS; EXTRACRANIAL APPROACH					
232	21267	ORBITAL REPOSITIONING, PERIORBITAL OSTEOTOMIES, UNILATERAL, WITH BONE GRAFTS; EXTRACRANIAL APPROACH					
232	21270	MALAR AUGMENTATION, PROSTHETIC MATERIAL					
232	21275	SECONDARY REVISION OF ORBITOCRANIOFACIAL RECONSTRUCTION					
232	21330	OPEN TREATMENT OF NASAL FRACTURE; COMPLICATED, WITH INTERNAL AND/OR EXTERNAL SKELETAL FIXATION					
232	21335	OPEN TREATMENT OF NASAL FRACTURE; WITH CONCOMITANT OPEN TREATMENT OF FRACTURED SEPTUM					
232	21338	OPEN TREATMENT OF NASOETHMOID FRACTURE; WITHOUT EXTERNAL FIXATION					
232	21339	OPEN TREATMENT OF NASOETHMOID FRACTURE; WITH EXTERNAL FIXATION					
232	21340	PERCUTANEOUS TREATMENT OF NASOETHMOID COMPLEX FRACTURE, WITH SPLINT, WIRE OR HEADCAP FIXATION, INCLUDING REPAIR OF CANTHAL LIGAMENTS AND/OR THE NASOLACRIMAL APPARATUS					
232	21343	OPEN TREATMENT OF DEPRESSED FRONTAL SINUS FRACTURE					
232	21345	CLOSED TREATMENT OF NASOMAXILLARY COMPLEX FRACTURE (LEFORT II TYPE), WITH INTERDENTAL WIRE FIXATION OR FIXATION OF DENTURE OR SPLINT					
232	21421	CLOSED TREATMENT OF PALATAL OR MAXILLARY FRACTURE (LEFORT I TYPE), WITH INTERDENTAL WIRE FIXATION OR FIXATION OF DENTURE OR SPLINT					
232	21445	OPEN TREATMENT OF MANDIBULAR OR MAXILLARY ALVEOLAR RIDGE FRACTURE (SEPARATE PROCEDURE)					

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
232	21450	CLOSED TREATMENT OF MANDIBULAR FRACTURE; WITHOUT MANIPULATION					
232	21452	PERCUTANEOUS TREATMENT OF MANDIBULAR FRACTURE, WITH EXTERNAL FIXATION					
232	21453	CLOSED TREATMENT OF MANDIBULAR FRACTURE WITH INTERDENTAL FIXATION					
232	21454	OPEN TREATMENT OF MANDIBULAR FRACTURE WITH EXTERNAL FIXATION					
232	21461	OPEN TREATMENT OF MANDIBULAR FRACTURE; WITHOUT INTERDENTAL FIXATION					
232	21462	OPEN TREATMENT OF MANDIBULAR FRACTURE; WITH INTERDENTAL FIXATION					
232	21465	OPEN TREATMENT OF MANDIBULAR CONDYLAR FRACTURE					
232	21490	OPEN TREATMENT OF TEMPOROMANDIBULAR DISLOCATION					
232	67420	ORBITOTOMY WITH BONE FLAP OR WINDOW, LATERAL APPROACH (EG, KROENLEIN); WITH REMOVAL OF LESION					
232	67430	ORBITOTOMY WITH BONE FLAP OR WINDOW, LATERAL APPROACH (EG, KROENLEIN); WITH REMOVAL OF FOREIGN BODY					
232	67440	ORBITOTOMY WITH BONE FLAP OR WINDOW, LATERAL APPROACH (EG, KROENLEIN); WITH DRAINAGE					
232	67450	ORBITOTOMY WITH BONE FLAP OR WINDOW, LATERAL APPROACH (EG, KROENLEIN); FOR EXPLORATION, WITH OR WITHOUT BIOPSY					
251	Level I musculoskeletal procedures		T	14.26	$722.55	$366.12	$144.51
251	20005	INCISION OF SOFT TISSUE ABSCESS (EG, SECONDARY TO OSTEOMYELITIS); DEEP OR COMPLICATED					
251	20250	BIOPSY, VERTEBRAL BODY, OPEN; THORACIC					
251	20251	BIOPSY, VERTEBRAL BODY, OPEN; LUMBAR OR CERVICAL					
251	20650	INSERTION OF WIRE OR PIN WITH APPLICATION OF SKELETAL TRACTION, INCLUDING REMOVAL (SEPARATE PROCEDURE)					
251	20693	ADJUSTMENT OR REVISION OF EXTERNAL FIXATION SYSTEM REQUIRING ANESTHESIA (EG, NEW PIN(S) OR WIRE(S) AND/OR NEW RING(S) OR BAR(S))					
251	20694	REMOVAL, UNDER ANESTHESIA, OF EXTERNAL FIXATION SYSTEM					
251	20975	ELECTRICAL STIMULATION TO AID BONE HEALING; INVASIVE (OPERATIVE)					
251	23100	ARTHROTOMY WITH BIOPSY, GLENOHUMERAL JOINT					
251	23140	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF CLAVICLE OR SCAPULA;					
251	23935	INCISION, DEEP, WITH OPENING OF BONE CORTEX (EG, FOR OSTEOMYELITIS OR BONE ABSCESS), HUMERUS OR ELBOW					
251	24100	ARTHROTOMY, ELBOW; WITH SYNOVIAL BIOPSY ONLY					
251	24105	EXCISION, OLECRANON BURSA					
251	24110	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR, HUMERUS;					
251	24120	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF HEAD OR NECK OF RADIUS OR OLECRANON PROCESS;					
251	24310	TENOTOMY, OPEN, ELBOW TO SHOULDER, SINGLE, EACH					
251	24925	AMPUTATION, ARM THROUGH HUMERUS; SECONDARY CLOSURE OR SCAR REVISION					
251	25000	TENDON SHEATH INCISION; AT RADIAL STYLOID (EG, FOR DEQUERVAIN'S DISEASE)					
251	25020	DECOMPRESSION FASCIOTOMY, FOREARM AND/OR WRIST; FLEXOR OR EXTENSOR COMPARTMENT					
251	25028	INCISION AND DRAINAGE, FOREARM AND/OR WRIST; DEEP ABSCESS OR HEMATOMA					
251	25031	INCISION AND DRAINAGE, FOREARM AND/OR WRIST; INFECTED BURSA					
251	25035	INCISION, DEEP, WITH OPENING OF BONE CORTEX (EG, FOR OSTEOMYELITIS OR BONE ABSCESS), FOREARM AND/OR WRIST					
251	25085	CAPSULOTOMY, WRIST (EG, FOR CONTRACTURE)					
251	25100	ARTHROTOMY, WRIST JOINT; WITH BIOPSY					
251	25110	EXCISION, LESION OF TENDON SHEATH, FOREARM AND/OR WRIST					
251	25115	RADICAL EXCISION OF BURSA, SYNOVIA OF WRIST, OR FOREARM TENDON SHEATHS (EG, TENOSYNOVITIS, FUNGUS, TBC, OR OTHER GRANULOMAS, RHEUMATOID ARTHRITIS); FLEXORS					
251	25116	RADICAL EXCISION OF BURSA, SYNOVIA OF WRIST, OR FOREARM TENDON SHEATHS (EG, TENOSYNOVITIS, FUNGUS, TBC, OR OTHER GRANULOMAS, RHEUMATOID ARTHRITIS); EXTENSORS, WITH OR WITHOUT TRANSPOSITION OF DORSAL RETINACULUM					
251	25248	EXPLORATION WITH REMOVAL OF DEEP FOREIGN BODY, FOREARM OR WRIST					
251	25295	TENOLYSIS, FLEXOR OR EXTENSOR TENDON, FOREARM AND/OR WRIST, SINGLE, EACH TENDON					
251	25907	AMPUTATION, FOREARM, THROUGH RADIUS AND ULNA; SECONDARY CLOSURE OR SCAR REVISION					
251	25922	DISARTICULATION THROUGH WRIST; SECONDARY CLOSURE OR SCAR REVISION					
251	26990	INCISION AND DRAINAGE, PELVIS OR HIP JOINT AREA; DEEP ABSCESS OR HEMATOMA					
251	26991	INCISION AND DRAINAGE, PELVIS OR HIP JOINT AREA; INFECTED BURSA					
251	27000	TENOTOMY, ADDUCTOR OF HIP, SUBCUTANEOUS, CLOSED (SEPARATE PROCEDURE)					
251	27050	ARTHROTOMY, WITH BIOPSY; SACROILIAC JOINT					
251	27052	ARTHROTOMY, WITH BIOPSY; HIP JOINT					
251	27060	EXCISION; ISCHIAL BURSA					
251	27062	EXCISION; TROCHANTERIC BURSA OR CALCIFICATION					
251	27065	EXCISION OF BONE CYST OR BENIGN TUMOR; SUPERFICIAL (WING OF ILIUM, SYMPHYSIS PUBIS, OR GREATER TROCHANTER OF FEMUR) WITH OR WITHOUT AUTOGRAFT					
251	27086	REMOVAL OF FOREIGN BODY, PELVIS OR HIP; SUBCUTANEOUS TISSUE					
251	27087	REMOVAL OF FOREIGN BODY, PELVIS OR HIP; DEEP					
251	27305	FASCIOTOMY, ILIOTIBIAL (TENOTOMY), OPEN					
251	27306	TENOTOMY, SUBCUTANEOUS, CLOSED, ADDUCTOR OR HAMSTRING, (SEPARATE PROCEDURE); SINGLE					
251	27307	TENOTOMY, SUBCUTANEOUS, CLOSED, ADDUCTOR OR HAMSTRING, (SEPARATE PROCEDURE); MULTIPLE					
251	27340	EXCISION, PREPATELLAR BURSA					
251	27345	EXCISION OF SYNOVIAL CYST OF POPLITEAL SPACE (BAKER'S CYST)					
251	27380	SUTURE OF INFRAPATELLAR TENDON; PRIMARY					
251	27381	SUTURE OF INFRAPATELLAR TENDON; SECONDARY RECONSTRUCTION, INCLUDING FASCIAL OR TENDON GRAFT					
251	27385	SUTURE OF QUADRICEPS OR HAMSTRING MUSCLE RUPTURE; PRIMARY					
251	27386	SUTURE OF QUADRICEPS OR HAMSTRING MUSCLE RUPTURE; SECONDARY RECONSTRUCTION, INCLUDING FASCIAL OR TENDON GRAFT					
251	27390	TENOTOMY, OPEN, HAMSTRING, KNEE TO HIP; SINGLE					
251	27391	TENOTOMY, OPEN, HAMSTRING, KNEE TO HIP; MULTIPLE, ONE LEG					
251	27392	TENOTOMY, OPEN, HAMSTRING, KNEE TO HIP; MULTIPLE, BILATERAL					
251	27496	DECOMPRESSION FASCIOTOMY, THIGH AND/OR KNEE, ONE COMPARTMENT (FLEXOR OR EXTENSOR OR ADDUCTOR);					
251	27497	DECOMPRESSION FASCIOTOMY, THIGH AND/OR KNEE, ONE COMPARTMENT (FLEXOR OR EXTENSOR OR ADDUCTOR); WITH DEBRIDEMENT OF NONVIABLE MUSCLE AND/OR NERVE					
251	27498	DECOMPRESSION FASCIOTOMY, THIGH AND/OR KNEE, MULTIPLE COMPARTMENTS;					

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
251	27499	DECOMPRESSION FASCIOTOMY, THIGH AND/OR KNEE, MULTIPLE COMPARTMENTS; WITH DEBRIDEMENT OF NONVIABLE MUSCLE AND/OR NERVE					
251	27594	AMPUTATION, THIGH, THROUGH FEMUR, ANY LEVEL; SECONDARY CLOSURE OR SCAR REVISION					
251	27600	DECOMPRESSION FASCIOTOMY, LEG; ANTERIOR AND/OR LATERAL COMPARTMENTS ONLY					
251	27601	DECOMPRESSION FASCIOTOMY, LEG; POSTERIOR COMPARTMENT(S) ONLY					
251	27602	DECOMPRESSION FASCIOTOMY, LEG; ANTERIOR AND/OR LATERAL, AND POSTERIOR COMPARTMENT(S)					
251	27604	INCISION AND DRAINAGE, LEG OR ANKLE; INFECTED BURSA					
251	27606	TENOTOMY, ACHILLES TENDON, SUBCUTANEOUS (SEPARATE PROCEDURE); GENERAL ANESTHESIA					
251	27607	INCISION, DEEP, WITH OPENING OF BONE CORTEX (EG, FOR OSTEOMYELITIS OR BONE ABSCESS), LEG OR ANKLE					
251	27630	EXCISION OF LESION OF TENDON SHEATH OR CAPSULE (EG, CYST OR GANGLION), LEG AND/OR ANKLE					
251	27656	REPAIR, FASCIAL DEFECT OF LEG					
251	27658	REPAIR OR SUTURE OF FLEXOR TENDON OF LEG; PRIMARY, WITHOUT GRAFT, SINGLE, EACH					
251	27659	REPAIR OR SUTURE OF FLEXOR TENDON OF LEG; SECONDARY WITH OR WITHOUT GRAFT, SINGLE TENDON, EACH					
251	27664	REPAIR OR SUTURE OF EXTENSOR TENDON OF LEG; PRIMARY, WITHOUT GRAFT, SINGLE, EACH					
251	27675	REPAIR FOR DISLOCATING PERONEAL TENDONS; WITHOUT FIBULAR OSTEOTOMY					
251	27704	REMOVAL OF ANKLE IMPLANT					
251	27707	OSTEOTOMY; FIBULA					
251	27884	AMPUTATION, LEG, THROUGH TIBIA AND FIBULA; SECONDARY CLOSURE OR SCAR REVISION					
251	27892	DECOMPRESSION FASCIOTOMY, LEG; ANTERIOR AND/OR LATERAL COMPARTMENTS ONLY, WITH DEBRIDEMENT OF NONVIABLE MUSCLE AND/OR NERVE					
251	27893	DECOMPRESSION FASCIOTOMY, LEG; POSTERIOR COMPARTMENT(S) ONLY, WITH DEBRIDEMENT OF NONVIABLE MUSCLE AND/OR NERVE					
251	27894	DECOMPRESSION FASCIOTOMY, LEG; ANTERIOR AND/OR LATERAL, AND POSTERIOR COMPARTMENT(S), WITH DEBRIDEMENT OF NONVIABLE MUSCLE AND/OR NERVE					
251	28002	DEEP DISSECTION BELOW FASCIA, FOR DEEP INFECTION OF FOOT, WITH OR WITHOUT TENDON SHEATH INVOLVEMENT; SINGLE BURSAL SPACE, SPECIFY					
251	28003	DEEP DISSECTION BELOW FASCIA, FOR DEEP INFECTION OF FOOT, WITH OR WITHOUT TENDON SHEATH INVOLVEMENT; MULTIPLE AREAS					
252	Level II Musculoskeletal Procedures		T	19.39	$982.48	$509.18	$196.5
252	20690	APPLICATION OF A UNIPLANE (PINS OR WIRES IN ONE PLANE), UNILATERAL, EXTERNAL FIXATION SYSTEM					
252	20692	APPLICATION OF A MULTIPLANE (PINS OR WIRES IN MORE THAN ONE PLANE), UNILATERAL, EXTERNAL FIXATION SYSTEM (EG, ILIZAROV, MONTICELLI TYPE)					
252	20900	BONE GRAFT, ANY DONOR AREA; MINOR OR SMALL (EG, DOWEL OR BUTTON)					
252	20902	BONE GRAFT, ANY DONOR AREA; MAJOR OR LARGE					
252	20924	TENDON GRAFT, FROM A DISTANCE (EG, PALMARIS, TOE EXTENSOR, PLANTARIS)					
252	21502	INCISION AND DRAINAGE, DEEP ABSCESS OR HEMATOMA, SOFT TISSUES OF NECK OR THORAX; WITH PARTIAL RIB OSTECTOMY					
252	21600	EXCISION OF RIB, PARTIAL					
252	21610	COSTOTRANSVERSECTOMY (SEPARATE PROCEDURE)					
252	23040	ARTHROTOMY, GLENOHUMERAL JOINT, FOR INFECTION, WITH EXPLORATION, DRAINAGE, OR REMOVAL OF FOREIGN BODY					
252	23044	ARTHROTOMY, ACROMIOCLAVICULAR, STERNOCLAVICULAR JOINT, FOR INFECTION, WITH EXPLORATION, DRAINAGE, OR REMOVAL OF FOREIGN BODY					
252	23101	ARTHROTOMY WITH BIOPSY, OR WITH EXCISION OF TORN CARTILAGE, ACROMIOCLAVICULAR, STERNOCLAVICULAR JOINT					
252	23105	ARTHROTOMY WITH SYNOVECTOMY; GLENOHUMERAL JOINT					
252	23106	ARTHROTOMY WITH SYNOVECTOMY; STERNOCLAVICULAR JOINT					
252	23107	ARTHROTOMY, GLENOHUMERAL JOINT, WITH JOINT EXPLORATION, WITH OR WITHOUT REMOVAL OF LOOSE OR FOREIGN BODY					
252	23145	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF CLAVICLE OR SCAPULA; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT)					
252	23146	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF CLAVICLE OR SCAPULA; WITH ALLOGRAFT					
252	23150	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF PROXIMAL HUMERUS;					
252	23155	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF PROXIMAL HUMERUS; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT)					
252	23156	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF PROXIMAL HUMERUS; WITH ALLOGRAFT					
252	23170	SEQUESTRECTOMY (EG, FOR OSTEOMYELITIS OR BONE ABSCESS), CLAVICLE					
252	23172	SEQUESTRECTOMY (EG, FOR OSTEOMYELITIS OR BONE ABSCESS), SCAPULA					
252	23174	SEQUESTRECTOMY (EG, FOR OSTEOMYELITIS OR BONE ABSCESS), HUMERAL HEAD TO SURGICAL NECK					
252	23180	PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR DIAPHYSECTOMY) OF BONE (EG, FOR OSTEOMYELITIS), CLAVICLE					
252	23182	PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR DIAPHYSECTOMY) OF BONE (EG, FOR OSTEOMYELITIS), SCAPULA					
252	23184	PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR DIAPHYSECTOMY) OF BONE (EG, FOR OSTEOMYELITIS), PROXIMAL HUMERUS					
252	23190	OSTECTOMY OF SCAPULA, PARTIAL (EG, SUPERIOR MEDIAL ANGLE)					
252	23405	TENOMYOTOMY, SHOULDER AREA; SINGLE					
252	23406	TENOMYOTOMY, SHOULDER AREA; MULTIPLE THROUGH SAME INCISION					
252	24000	ARTHROTOMY, ELBOW, FOR INFECTION, WITH EXPLORATION, DRAINAGE OR REMOVAL OF FOREIGN BODY					
252	24006	ARTHROTOMY OF THE ELBOW, WITH CAPSULAR EXCISION FOR CAPSULAR RELEASE (SEPARATE PROCEDURE)					
252	24101	ARTHROTOMY, ELBOW; WITH JOINT EXPLORATION, WITH OR WITHOUT BIOPSY, WITH OR WITHOUT REMOVAL OF LOOSE OR FOREIGN BODY					
252	24102	ARTHROTOMY, ELBOW; WITH SYNOVECTOMY					
252	24115	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR, HUMERUS; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT)					
252	24116	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR, HUMERUS; WITH ALLOGRAFT					
252	24125	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF HEAD OR NECK OF RADIUS OR OLECRANON PROCESS; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT)					
252	24126	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF HEAD OR NECK OF RADIUS OR OLECRANON PROCESS; WITH ALLOGRAFT					
252	24130	EXCISION, RADIAL HEAD					
252	24134	SEQUESTRECTOMY (EG, FOR OSTEOMYELITIS OR BONE ABSCESS), SHAFT OR DISTAL HUMERUS					

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
252	24136	SEQUESTRECTOMY (EG, FOR OSTEOMYELITIS OR BONE ABSCESS), RADIAL HEAD OR NECK					
252	24138	SEQUESTRECTOMY (EG, FOR OSTEOMYELITIS OR BONE ABSCESS), OLECRANON PROCESS					
252	24140	PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR DIAPHYSECTOMY) OF BONE (EG, FOR OSTEOMYELITIS), HUMERUS					
252	24145	PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR DIAPHYSECTOMY) OF BONE (EG, FOR OSTEOMYELITIS), RADIAL HEAD OR NECK					
252	24147	PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR DIAPHYSECTOMY) OF BONE (EG, FOR OSTEOMYELITIS), OLECRANON PROCESS					
252	24160	IMPLANT REMOVAL; ELBOW JOINT					
252	24164	IMPLANT REMOVAL; RADIAL HEAD					
252	24301	MUSCLE OR TENDON TRANSFER, ANY TYPE, UPPER ARM OR ELBOW, SINGLE (EXCLUDING 24320-24331)					
252	24305	TENDON LENGTHENING, UPPER ARM OR ELBOW, SINGLE, EACH					
252	24350	FASCIOTOMY, LATERAL OR MEDIAL (EG, ''TENNIS ELBOW'' OR EPICONDYLITIS);					
252	24351	FASCIOTOMY, LATERAL OR MEDIAL (EG, ''TENNIS ELBOW'' OR EPICONDYLITIS); WITH EXTENSOR ORIGIN DETACHMENT					
252	24352	FASCIOTOMY, LATERAL OR MEDIAL (EG, ''TENNIS ELBOW'' OR EPICONDYLITIS); WITH ANNULAR LIGAMENT RESECTION					
252	24354	FASCIOTOMY, LATERAL OR MEDIAL (EG, ''TENNIS ELBOW'' OR EPICONDYLITIS); WITH STRIPPING					
252	24356	FASCIOTOMY, LATERAL OR MEDIAL (EG, ''TENNIS ELBOW'' OR EPICONDYLITIS); WITH PARTIAL OSTECTOMY					
252	24400	OSTEOTOMY, HUMERUS, WITH OR WITHOUT INTERNAL FIXATION					
252	24410	MULTIPLE OSTEOTOMIES WITH REALIGNMENT ON INTRAMEDULLARY ROD, HUMERAL SHAFT (SOFIELD TYPE PROCEDURE)					
252	24495	DECOMPRESSION FASCIOTOMY, FOREARM, WITH BRACHIAL ARTERY EXPLORATION					
252	25023	DECOMPRESSION FASCIOTOMY, FOREARM AND/OR WRIST; WITH DEBRIDEMENT OF NONVIABLE MUSCLE AND/OR NERVE					
252	25040	ARTHROTOMY, RADIOCARPAL OR MIDCARPAL JOINT, WITH EXPLORATION, DRAINAGE, OR REMOVAL OF FOREIGN BODY					
252	25101	ARTHROTOMY, WRIST JOINT; WITH JOINT EXPLORATION, WITH OR WITHOUT BIOPSY, WITH OR WITHOUT REMOVAL OF LOOSE OR FOREIGN BODY					
252	25105	ARTHROTOMY, WRIST JOINT; WITH SYNOVECTOMY					
252	25107	ARTHROTOMY, DISTAL RADIOULNAR JOINT FOR REPAIR OF TRIANGULAR CARTILAGE COMPLEX					
252	25118	SYNOVECTOMY, EXTENSOR TENDON SHEATH, WRIST, SINGLE COMPARTMENT;					
252	25119	SYNOVECTOMY, EXTENSOR TENDON SHEATH, WRIST, SINGLE COMPARTMENT; WITH RESECTION OF DISTAL ULNA					
252	25120	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF RADIUS OR ULNA (EXCLUDING HEAD OR NECK OF RADIUS AND OLECRANON PROCESS);					
252	25125	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF RADIUS OR ULNA (EXCLUDING HEAD OR NECK OF RADIUS AND OLECRANON PROCESS); WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT)					
252	25126	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF RADIUS OR ULNA (EXCLUDING HEAD OR NECK OF RADIUS AND OLECRANON PROCESS); WITH ALLOGRAFT					
252	25130	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF CARPAL BONES;					
252	25135	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF CARPAL BONES; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT)					
252	25136	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF CARPAL BONES; WITH ALLOGRAFT					
252	25145	SEQUESTRECTOMY (EG, FOR OSTEOMYELITIS OR BONE ABSCESS), FOREARM AND/OR WRIST					
252	25150	PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR DIAPHYSECTOMY) OF BONE (EG, FOR OSTEOMYELITIS); ULNA					
252	25151	PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR DIAPHYSECTOMY) OF BONE (EG, FOR OSTEOMYELITIS); RADIUS					
252	25230	RADIAL STYLOIDECTOMY (SEPARATE PROCEDURE)					
252	25240	EXCISION DISTAL ULNA PARTIAL OR COMPLETE (EG, DARRACH TYPE OR MATCHED RESECTION)					
252	25250	REMOVAL OF WRIST PROSTHESIS; (SEPARATE PROCEDURE)					
252	25251	REMOVAL OF WRIST PROSTHESIS; COMPLICATED, INCLUDING ''TOTAL WRIST''					
252	25260	REPAIR, TENDON OR MUSCLE, FLEXOR, FOREARM AND/OR WRIST; PRIMARY, SINGLE, EACH TENDON OR MUSCLE					
252	25263	REPAIR, TENDON OR MUSCLE, FLEXOR, FOREARM AND/OR WRIST; SECONDARY, SINGLE, EACH TENDON OR MUSCLE					
252	25265	REPAIR, TENDON OR MUSCLE, FLEXOR, FOREARM AND/OR WRIST; SECONDARY, WITH FREE GRAFT (INCLUDES OBTAINING GRAFT), EACH TENDON OR MUSCLE					
252	25270	REPAIR, TENDON OR MUSCLE, EXTENSOR, FOREARM AND/OR WRIST; PRIMARY, SINGLE, EACH TENDON OR MUSCLE					
252	25272	REPAIR, TENDON OR MUSCLE, EXTENSOR, FOREARM AND/OR WRIST; SECONDARY, SINGLE, EACH TENDON OR MUSCLE					
252	25274	REPAIR, TENDON OR MUSCLE, EXTENSOR, SECONDARY, WITH TENDON GRAFT (INCLUDES OBTAINING GRAFT), FOREARM AND/OR WRIST, EACH TENDON OR MUSCLE					
252	25280	LENGTHENING OR SHORTENING OF FLEXOR OR EXTENSOR TENDON, FOREARM AND/OR WRIST, SINGLE, EACH TENDON					
252	25290	TENOTOMY, OPEN, FLEXOR OR EXTENSOR TENDON, FOREARM AND/OR WRIST, SINGLE, EACH TENDON					
252	25300	TENODESIS AT WRIST; FLEXORS OF FINGERS					
252	25301	TENODESIS AT WRIST; EXTENSORS OF FINGERS					
252	25360	OSTEOTOMY; ULNA					
252	25365	OSTEOTOMY; RADIUS AND ULNA					
252	25400	REPAIR OF NONUNION OR MALUNION, RADIUS OR ULNA; WITHOUT GRAFT (EG, COMPRESSION TECHNIQUE)					
252	25415	REPAIR OF NONUNION OR MALUNION, RADIUS AND ULNA; WITHOUT GRAFT (EG, COMPRESSION TECHNIQUE)					
252	27001	TENOTOMY, ADDUCTOR OF HIP, SUBCUTANEOUS, OPEN					
252	27003	TENOTOMY, ADDUCTOR, SUBCUTANEOUS, OPEN, WITH OBTURATOR NEURECTOMY					
252	27066	EXCISION OF BONE CYST OR BENIGN TUMOR; DEEP, WITH OR WITHOUT AUTOGRAFT					
252	27067	EXCISION OF BONE CYST OR BENIGN TUMOR; WITH AUTOGRAFT REQUIRING SEPARATE INCISION					
252	27080	COCCYGECTOMY, PRIMARY					
252	27097	HAMSTRING RECESSION, PROXIMAL					
252	27098	ADDUCTOR TRANSFER TO ISCHIUM					
252	27310	ARTHROTOMY, KNEE, FOR INFECTION, WITH EXPLORATION, DRAINAGE OR REMOVAL OF FOREIGN BODY					
252	27330	ARTHROTOMY, KNEE; WITH SYNOVIAL BIOPSY ONLY					
252	27331	ARTHROTOMY, KNEE; WITH JOINT EXPLORATION, WITH OR WITHOUT BIOPSY, WITH OR WITHOUT REMOVAL OF LOOSE OR FOREIGN BODIES					
252	27332	ARTHROTOMY, KNEE, WITH EXCISION OF SEMILUNAR CARTILAGE (MENISCECTOMY); MEDIAL OR LATERAL					
252	27333	ARTHROTOMY, KNEE, WITH EXCISION OF SEMILUNAR CARTILAGE (MENISCECTOMY); MEDIAL AND LATERAL					
252	27334	ARTHROTOMY, KNEE, WITH SYNOVECTOMY; ANTERIOR OR POSTERIOR					
252	27335	ARTHROTOMY, KNEE, WITH SYNOVECTOMY; ANTERIOR AND POSTERIOR INCLUDING POPLITEAL AREA					
252	27350	PATELLECTOMY OR HEMIPATELLECTOMY					

(See Addendum D. for Payment of Medical Visits)

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
252	27355	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF FEMUR;					
252	27356	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF FEMUR; WITH ALLOGRAFT					
252	27357	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF FEMUR; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT)					
252	27358	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF FEMUR; WITH INTERNAL FIXATION (LIST IN ADDITION TO 27355, 27356, OR 27357)					
252	27360	PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR DIAPHYSECTOMY) OF BONE (EG, FOR OSTEOMYELITIS), FEMUR, PROXIMAL TIBIA AND/ OR FIBULA					
252	27393	LENGTHENING OF HAMSTRING TENDON; SINGLE					
252	27394	LENGTHENING OF HAMSTRING TENDON; MULTIPLE, ONE LEG					
252	27396	TRANSPLANT, HAMSTRING TENDON TO PATELLA; SINGLE					
252	27403	ARTHROTOMY WITH OPEN MENISCUS REPAIR					
252	27425	LATERAL RETINACULAR RELEASE (ANY METHOD)					
252	27610	ARTHROTOMY, ANKLE, FOR INFECTION, WITH EXPLORATION, DRAINAGE, OR REMOVAL OF FOREIGN BODY					
252	27612	ARTHROTOMY, ANKLE, POSTERIOR CAPSULAR RELEASE, WITH OR WITHOUT ACHILLES TENDON LENGTHENING					
252	27620	ARTHROTOMY, ANKLE, WITH JOINT EXPLORATION, WITH OR WITHOUT BIOPSY, WITH OR WITHOUT REMOVAL OF LOOSE OR FOREIGN BODY					
252	27625	ARTHROTOMY, ANKLE, WITH SYNOVECTOMY;					
252	27626	ARTHROTOMY, ANKLE, WITH SYNOVECTOMY; INCLUDING TENOSYNOVECTOMY					
252	27635	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR, TIBIA OR FIBULA;					
252	27637	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR, TIBIA OR FIBULA; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT)					
252	27638	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR, TIBIA OR FIBULA; WITH ALLOGRAFT					
252	27641	PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR DIAPHYSECTOMY) OF BONE (EG, FOR OSTEOMYELITIS OR EXOSTOSIS); FIBULA					
252	27665	REPAIR OR SUTURE OF EXTENSOR TENDON OF LEG; SECONDARY WITH OR WITHOUT GRAFT, SINGLE TENDON, EACH					
252	27676	REPAIR FOR DISLOCATING PERONEAL TENDONS; WITH FIBULAR OSTEOTOMY					
252	27680	TENOLYSIS, INCLUDING TIBIA, FIBULA, AND ANKLE FLEXOR; SINGLE					
252	27681	TENOLYSIS, INCLUDING TIBIA, FIBULA, AND ANKLE FLEXOR; MULTIPLE (THROUGH SAME INCISION), EACH					
252	27685	LENGTHENING OR SHORTENING OF TENDON, LEG OR ANKLE; SINGLE (SEPARATE PROCEDURE)					
252	27686	LENGTHENING OR SHORTENING OF TENDON, LEG OR ANKLE; MULTIPLE (THROUGH SAME INCISION), EACH					
252	27687	GASTROCNEMIUS RECESSION (EG, STRAYER PROCEDURE)					
252	27695	SUTURE, PRIMARY, TORN, RUPTURED OR SEVERED LIGAMENT, ANKLE; COLLATERAL					
252	27696	SUTURE, PRIMARY, TORN, RUPTURED OR SEVERED LIGAMENT, ANKLE; BOTH COLLATERAL LIGAMENTS					
252	27698	SUTURE, SECONDARY REPAIR, TORN, RUPTURED OR SEVERED LIGAMENT, ANKLE, COLLATERAL (EG, WATSON-JONES PROCEDURE)					
252	27709	OSTEOTOMY; TIBIA AND FIBULA					
252	27730	EPIPHYSEAL ARREST BY EPIPHYSIODESIS OR STAPLING; DISTAL TIBIA					
252	27732	EPIPHYSEAL ARREST BY EPIPHYSIODESIS OR STAPLING; DISTAL FIBULA					
252	27734	EPIPHYSEAL ARREST BY EPIPHYSIODESIS OR STAPLING; DISTAL TIBIA AND FIBULA					
252	27740	EPIPHYSEAL ARREST BY EPIPHYSIODESIS OR STAPLING, COMBINED, PROXIMAL AND DISTAL TIBIA AND FIBULA;					
252	27889	ANKLE DISARTICULATION					
253	Level III Musculoskeletal Procedures		T	26.33	$1,334.13	$699.24	$266.83
253	23020	CAPSULAR CONTRACTURE RELEASE (SEVER TYPE PROCEDURE)					
253	23120	CLAVICULECTOMY; PARTIAL					
253	23130	ACROMIOPLASTY OR ACROMIONECTOMY, PARTIAL					
253	23415	CORACOACROMIAL LIGAMENT RELEASE, WITH OR WITHOUT ACROMIOPLASTY					
253	23480	OSTEOTOMY, CLAVICLE, WITH OR WITHOUT INTERNAL FIXATION;					
253	23485	OSTEOTOMY, CLAVICLE, WITH OR WITHOUT INTERNAL FIXATION; WITH BONE GRAFT FOR NONUNION OR MALUNION (INCLUDES OBTAINING GRAFT AND/OR NECESSARY FIXATION)					
253	23490	PROPHYLACTIC TREATMENT (NAILING, PINNING, PLATING OR WIRING) WITH OR WITHOUT METHYLMETHACRYLATE; CLAVICLE					
253	23491	PROPHYLACTIC TREATMENT (NAILING, PINNING, PLATING OR WIRING) WITH OR WITHOUT METHYLMETHACRYLATE; PROXIMAL HUMERUS AND HUMERAL HEAD					
253	23800	ARTHRODESIS, SHOULDER JOINT; WITH OR WITHOUT LOCAL BONE GRAFT					
253	23802	ARTHRODESIS, SHOULDER JOINT; WITH PRIMARY AUTOGENOUS GRAFT (INCLUDES OBTAINING GRAFT)					
253	24155	RESECTION OF ELBOW JOINT (ARTHRECTOMY)					
253	24320	TENOPLASTY, WITH MUSCLE TRANSFER, WITH OR WITHOUT FREE GRAFT, ELBOW TO SHOULDER, SINGLE (SEDDON-BROOKES TYPE PROCEDURE)					
253	24330	FLEXOR-PLASTY, ELBOW (EG, STEINDLER TYPE ADVANCEMENT);					
253	24331	FLEXOR-PLASTY, ELBOW (EG, STEINDLER TYPE ADVANCEMENT); WITH EXTENSOR ADVANCEMENT					
253	24340	TENODESIS OF BICEPS TENDON AT ELBOW (SEPARATE PROCEDURE)					
253	24341	REPAIR, TENDON OR MUSCLE, UPPER ARM OR ELBOW, EACH TENDON OR MUSCLE, PRIMARY OR SECONDARY (EXCLUDES ROTATOR CUFF)					
253	24342	REINSERTION OF RUPTURED BICEPS OR TRICEPS TENDON, DISTAL, WITH OR WITHOUT TENDON GRAFT					
253	24420	OSTEOPLASTY, HUMERUS (EG, SHORTENING OR LENGTHENING) (EXCLUDING 64876)					
253	24430	REPAIR OF NONUNION OR MALUNION, HUMERUS; WITHOUT GRAFT (EG, COMPRESSION TECHNIQUE)					
253	24435	REPAIR OF NONUNION OR MALUNION, HUMERUS; WITH ILIAC OR OTHER AUTOGRAFT (INCLUDES OBTAINING GRAFT)					
253	24470	HEMIEPIPHYSEAL ARREST (EG, FOR CUBITUS VARUS OR VALGUS, DISTAL HUMERUS)					
253	24498	PROPHYLACTIC TREATMENT (NAILING, PINNING, PLATING OR WIRING), WITH OR WITHOUT METHYLMETHACRYLATE, HUMERUS					
253	24800	ARTHRODESIS, ELBOW JOINT; WITH OR WITHOUT LOCAL AUTOGRAFT OR ALLOGRAFT					
253	24802	ARTHRODESIS, ELBOW JOINT; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT OTHER THAN LOCALLY OBTAINED)					
253	25310	TENDON TRANSPLANTATION OR TRANSFER, FLEXOR OR EXTENSOR, FOREARM AND/OR WRIST, SINGLE; EACH TENDON					
253	25312	TENDON TRANSPLANTATION OR TRANSFER, FLEXOR OR EXTENSOR, FOREARM AND/OR WRIST, SINGLE; WITH TENDON GRAFT(S) (INCLUDES OBTAINING GRAFT), EACH TENDON					
253	25315	FLEXOR ORIGIN SLIDE (EG, FOR CEREBRAL PALSY, VOLKMANN CONTRACTURE), FOREARM AND/OR WRIST;					
253	25316	FLEXOR ORIGIN SLIDE (EG, FOR CEREBRAL PALSY, VOLKMANN CONTRACTURE), FOREARM AND/OR WRIST; WITH TENDON(S) TRANSFER					
253	25320	CAPSULORRHAPHY OR RECONSTRUCTION, WRIST, ANY METHOD (EG, CAPSULODESIS, LIGAMENT REPAIR, TENDON TRANSFER OR GRAFT) (INCLUDES SYNOVECTOMY, CAPSULOTOMY AND OPEN REDUCTION) FOR CARPAL INSTABILITY					

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
253	25335	CENTRALIZATION OF WRIST ON ULNA (EG, RADIAL CLUB HAND)					
253	25337	RECONSTRUCTION FOR STABILIZATION OF UNSTABLE DISTAL ULNA OR DISTAL RADIOULNAR JOINT, SECONDARY BY SOFT TISSUE STABILIZATION (EG, TENDON TRANSFER, TENDON GRAFT OR WEAVE, OR TENODESIS) WITH OR WITHOUT OPEN REDUCTION OF DISTAL RADIOULNAR JOINT					
253	25350	OSTEOTOMY, RADIUS; DISTAL THIRD					
253	25355	OSTEOTOMY, RADIUS; MIDDLE OR PROXIMAL THIRD					
253	25370	MULTIPLE OSTEOTOMIES, WITH REALIGNMENT ON INTRAMEDULLARY ROD (SOFIELD TYPE PROCEDURE); RADIUS OR ULNA					
253	25375	MULTIPLE OSTEOTOMIES, WITH REALIGNMENT ON INTRAMEDULLARY ROD (SOFIELD TYPE PROCEDURE); RADIUS AND ULNA					
253	25425	REPAIR OF DEFECT WITH AUTOGRAFT; RADIUS OR ULNA					
253	25426	REPAIR OF DEFECT WITH AUTOGRAFT; RADIUS AND ULNA					
253	25440	REPAIR OF NONUNION, SCAPHOID (NAVICULAR) BONE, WITH OR WITHOUT RADIAL STYLOIDECTOMY (INCLUDES OBTAINING GRAFT AND NECESSARY FIXATION)					
253	25450	EPIPHYSEAL ARREST BY EPIPHYSIODESIS OR STAPLING; DISTAL RADIUS OR ULNA					
253	25455	EPIPHYSEAL ARREST BY EPIPHYSIODESIS OR STAPLING; DISTAL RADIUS AND ULNA					
253	25490	PROPHYLACTIC TREATMENT (NAILING, PINNING, PLATING OR WIRING) WITH OR WITHOUT METHYLMETHACRYLATE; RADIUS					
253	25491	PROPHYLACTIC TREATMENT (NAILING, PINNING, PLATING OR WIRING) WITH OR WITHOUT METHYLMETHACRYLATE; ULNA					
253	25492	PROPHYLACTIC TREATMENT (NAILING, PINNING, PLATING OR WIRING) WITH OR WITHOUT METHYLMETHACRYLATE; RADIUS AND VLNA					
253	25800	ARTHRODESIS, WRIST JOINT (INCLUDING RADIOCARPAL AND/OR ULNOCARPAL FUSION); WITHOUT BONE GRAFT					
253	25805	ARTHRODESIS, WRIST JOINT (INCLUDING RADIOCARPAL AND/OR ULNOCARPAL FUSION); WITH SLIDING GRAFT					
253	25810	ARTHRODESIS, WRIST JOINT (INCLUDING RADIOCARPAL AND/OR ULNOCARPAL FUSION); WITH ILIAC OR OTHER AUTOGRAFT (INCLUDES OBTAINING GRAFT)					
253	25830	DISTAL RADIOULNAR JOINT ARTHRODESIS AND SEGMENTAL RESECTION OF ULNA (EG, SAUVE-KAPANDJI PROCEDURE), WITH OR WITHOUT BONE GRAFT					
253	27033	ARTHROTOMY, HIP, WITH EXPLORATION OR REMOVAL OF LOOSE OR FOREIGN BODY					
253	27100	TRANSFER EXTERNAL OBLIQUE MUSCLE TO GREATER TROCHANTER INCLUDING FASCIAL OR TENDON EXTENSION (GRAFT)					
253	27105	TRANSFER PARASPINAL MUSCLE TO HIP (INCLUDES FASCIAL OR TENDON EXTENSION GRAFT)					
253	27110	TRANSFER ILIOPSOAS; TO GREATER TROCHANTER					
253	27111	TRANSFER ILIOPSOAS; TO FEMORAL NECK					
253	27395	LENGTHENING OF HAMSTRING TENDON; MULTIPLE, BILATERAL					
253	27397	TRANSPLANT, HAMSTRING TENDON TO PATELLA; MULTIPLE					
253	27400	TENDON OR MUSCLE TRANSFER, HAMSTRINGS TO FEMUR (EGGERS TYPE PROCEDURE)					
253	27405	REPAIR, PRIMARY, TORN LIGAMENT AND/OR CAPSULE, KNEE; COLLATERAL					
253	27407	REPAIR, PRIMARY, TORN LIGAMENT AND/OR CAPSULE, KNEE; CRUCIATE					
253	27409	REPAIR, PRIMARY, TORN LIGAMENT AND/OR CAPSULE, KNEE; COLLATERAL AND CRUCIATE LIGAMENTS					
253	27418	ANTERIOR TIBIAL TUBERCLEPLASTY (EG, FOR CHONDROMALACIA PATELLAE)					
253	27420	RECONSTRUCTION FOR RECURRENT DISLOCATING PATELLA; (HAUSER TYPE PROCEDURE)					
253	27422	RECONSTRUCTION FOR RECURRENT DISLOCATING PATELLA; WITH EXTENSOR REALIGNMENT AND/OR MUSCLE ADVANCEMENT OR RELEASE (CAMPBELL, GOLDWAITE TYPE PROCEDURE)					
253	27424	RECONSTRUCTION FOR RECURRENT DISLOCATING PATELLA; WITH PATELLECTOMY					
253	27430	QUADRICEPSPLASTY (BENNETT OR THOMPSON TYPE)					
253	27435	CAPSULOTOMY, KNEE, POSTERIOR CAPSULAR RELEASE					
253	27640	PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR DIAPHYSECTOMY) OF BONE (EG, FOR OSTEOMYELITIS OR EXOSTOSIS); TIBIA					
253	27647	RADICAL RESECTION OF TUMOR, BONE; TALUS OR CALCANEUS					
253	27650	REPAIR, PRIMARY, OPEN OR PERCUTANEOUS, RUPTURED ACHILLES TENDON;					
253	27652	REPAIR, PRIMARY, OPEN OR PERCUTANEOUS, RUPTURED ACHILLES TENDON; WITH GRAFT (INCLUDES OBTAINING GRAFT)					
253	27654	REPAIR, SECONDARY, RUPTURED ACHILLES TENDON, WITH OR WITHOUT GRAFT					
253	27690	TRANSFER OR TRANSPLANT OF SINGLE TENDON (WITH MUSCLE REDIRECTION OR REROUTING); SUPERFICIAL (EG, ANTERIOR TIBIAL EXTENSORS INTO MIDFOOT)					
253	27691	TRANSFER OR TRANSPLANT OF SINGLE TENDON (WITH MUSCLE REDIRECTION OR REROUTING); DEEP (EG, ANTERIOR TIBIAL OR POSTERIOR TIBIAL THROUGH INTEROSSEOUS SPACE, FLEXOR DIGITORUM LONGUS, FLEXOR HALLUCIS LONGUS, OR PERONEAL TENDON TO MIDFOOT OR HINDFOOT)					
253	27692	TRANSFER OR TRANSPLANT OF SINGLE TENDON (WITH MUSCLE REDIRECTION OR REROUTING); EACH ADDITIONAL TENDON					
253	27705	OSTEOTOMY; TIBIA					
253	27742	EPIPHYSEAL ARREST BY EPIPHYSIODESIS OR STAPLING, COMBINED, PROXIMAL AND DISTAL TIBIA AND FIBULA; AND DISTAL FEMUR					
253	27745	PROPHYLACTIC TREATMENT (NAILING, PINNING, PLATING OR WIRING) WITH OR WITHOUT METHYLMETHACRYLATE, TIBIA					
253	27870	ARTHRODESIS, ANKLE, ANY METHOD					
253	27871	ARTHRODESIS, TIBIOFIBULAR JOINT, PROXIMAL OR DISTAL					
254	Level IV Musculoskeletal Procedures		T	34.37	$1,741.51	$937.11	$348.30
254	23410	REPAIR OF RUPTURED MUSCULOTENDINOUS CUFF (EG, ROTATOR CUFF); ACUTE					
254	23412	REPAIR OF RUPTURED MUSCULOTENDINOUS CUFF (EG, ROTATOR CUFF); CHRONIC					
254	23420	REPAIR OF COMPLETE SHOULDER (ROTATOR) CUFF AVULSION, CHRONIC (INCLUDES ACROMIOPLASTY)					
254	23430	TENODESIS OF LONG TENDON OF BICEPS					
254	23450	CAPSULORRHAPHY, ANTERIOR; PUTTI-PLATT PROCEDURE OR MAGNUSON TYPE OPERATION					
254	23455	CAPSULORRHAPHY, ANTERIOR; BANKART TYPE OPERATION WITH OR WITHOUT STAPLING					
254	23460	CAPSULORRHAPHY, ANTERIOR, ANY TYPE; WITH BONE BLOCK					
254	23462	CAPSULORRHAPHY, ANTERIOR, ANY TYPE; WITH CORACOID PROCESS TRANSFER					
254	23465	CAPSULORRHAPHY FOR RECURRENT DISLOCATION, POSTERIOR, WITH OR WITHOUT BONE BLOCK					
254	23466	CAPSULORRHAPHY WITH ANY TYPE MULTI-DIRECTIONAL INSTABILITY					
254	27427	LIGAMENTOUS RECONSTRUCTION (AUGMENTATION), KNEE; EXTRA-ARTICULAR					
254	27428	LIGAMENTOUS RECONSTRUCTION (AUGMENTATION), KNEE; INTRA-ARTICULAR (OPEN)					
254	27429	LIGAMENTOUS RECONSTRUCTION (AUGMENTATION), KNEE; INTRA-ARTICULAR (OPEN) AND EXTRA-ARTICULAR					
261	Level I Hand Musculoskeletal Procedures		T	10.54	$534.06	$261.48	$106.81
261	25111	EXCISION OF GANGLION, WRIST (DORSAL OR VOLAR); PRIMARY					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
261	25112	EXCISION OF GANGLION, WRIST (DORSAL OR VOLAR); RECURRENT					
261	25820	INTERCARPAL FUSION; WITHOUT BONE GRAFT					
261	26020	DRAINAGE OF TENDON SHEATH, ONE DIGIT AND/OR PALM					
261	26025	DRAINAGE OF PALMAR BURSA; SINGLE, ULNAR OR RADIAL					
261	26030	DRAINAGE OF PALMAR BURSA; MULTIPLE OR COMPLICATED					
261	26034	INCISION, DEEP, WITH OPENING OF BONE CORTEX (EG, FOR OSTEOMYELITIS OR BONE ABSCESS), HAND OR FINGER					
261	26035	DECOMPRESSION FINGERS AND/OR HAND, INJECTION INJURY (EG, GREASE GUN)					
261	26037	DECOMPRESSIVE FASCIOTOMY, HAND (EXCLUDES 26035)					
261	26055	TENDON SHEATH INCISION (EG, FOR TRIGGER FINGER)					
261	26060	TENOTOMY, PERCUTANEOUS, SINGLE, EACH DIGIT					
261	26070	ARTHROTOMY, WITH EXPLORATION, DRAINAGE, OR REMOVAL OF FOREIGN BODY; CARPOMETACARPAL JOINT					
261	26075	ARTHROTOMY, WITH EXPLORATION, DRAINAGE, OR REMOVAL OF FOREIGN BODY; METACARPOPHALANGEAL JOINT					
261	26080	ARTHROTOMY, WITH EXPLORATION, DRAINAGE, OR REMOVAL OF FOREIGN BODY; INTERPHALANGEAL JOINT, EACH					
261	26100	ARTHROTOMY WITH SYNOVIAL BIOPSY; CARPOMETACARPAL JOINT					
261	26105	ARTHROTOMY WITH SYNOVIAL BIOPSY; METACARPOPHALANGEAL JOINT					
261	26110	ARTHROTOMY WITH SYNOVIAL BIOPSY; INTERPHALANGEAL JOINT, EACH					
261	26130	SYNOVECTOMY, CARPOMETACARPAL JOINT					
261	26140	SYNOVECTOMY, PROXIMAL INTERPHALANGEAL JOINT, INCLUDING EXTENSOR RECONSTRUCTION, EACH INTERPHALANGEAL					
261	26145	SYNOVECTOMY TENDON SHEATH, RADICAL (TENOSYNOVECTOMY), FLEXOR, PALM OR FINGER, SINGLE, EACH DIGIT					
261	26160	EXCISION OF LESION OF TENDON SHEATH OR CAPSULE (EG, CYST, MUCOUS CYST, OR GANGLION), HAND OR FINGER					
261	26170	EXCISION OF TENDON, PALM, FLEXOR, SINGLE (SEPARATE PROCEDURE), EACH					
261	26180	EXCISION OF TENDON, FINGER, FLEXOR (SEPARATE PROCEDURE)					
261	26185	SESAMOIDECTOMY, THUMB OR FINGER (SEPARATE PROCEDURE)					
261	26200	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF METACARPAL;					
261	26210	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF PROXIMAL, MIDDLE, OR DISTAL PHALANX OF FINGER;					
261	26215	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF PROXIMAL, MIDDLE, OR DISTAL PHALANX OF FINGER; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT)					
261	26230	PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR DIAPHYSECTOMY) OF BONE (EG, FOR OSTEOMYELITIS); METACARPAL					
261	26235	PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR DIAPHYSECTOMY) OF BONE (EG, FOR OSTEOMYELITIS); PROXIMAL OR MIDDLE PHALANX OF FINGER					
261	26236	PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR DIAPHYSECTOMY) OF BONE (EG, FOR OSTEOMYELITIS); DISTAL PHALANX OF FINGER					
261	26250	RADICAL RESECTION (OSTECTOMY) FOR TUMOR, METACARPAL;					
261	26260	RADICAL RESECTION (OSTECTOMY) FOR TUMOR, PROXIMAL OR MIDDLE PHALANX OF FINGER;					
261	26261	RADICAL RESECTION (OSTECTOMY) FOR TUMOR, PROXIMAL OR MIDDLE PHALANX OF FINGER; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT)					
261	26262	RADICAL RESECTION (OSTECTOMY) FOR TUMOR, DISTAL PHALANX OF FINGER					
261	26410	EXTENSOR TENDON REPAIR, DORSUM OF HAND, SINGLE, PRIMARY OR SECONDARY; WITHOUT FREE GRAFT, EACH TENDON					
261	26418	EXTENSOR TENDON REPAIR, DORSUM OF FINGER, SINGLE, PRIMARY OR SECONDARY; WITHOUT FREE GRAFT, EACH TENDON					
261	26432	EXTENSOR TENDON REPAIR, DISTAL INSERTION (''MALLET FINGER''), CLOSED, SPLINTING WITH OR WITHOUT PERCUTANEOUS PINNING					
261	26433	EXTENSOR TENDON REPAIR, DISTAL INSERTION (''MALLET FINGER''), OPEN, PRIMARY OR SECONDARY REPAIR; WITHOUT GRAFT					
261	26437	EXTENSOR TENDON REALIGNMENT, HAND					
261	26440	TENOLYSIS, SIMPLE, FLEXOR TENDON; PALM OR FINGER, SINGLE, EACH TENDON					
261	26445	TENOLYSIS, EXTENSOR TENDON, DORSUM OF HAND OR FINGER; EACH TENDON					
261	26450	TENOTOMY, FLEXOR, SINGLE, PALM, OPEN, EACH					
261	26455	TENOTOMY, FLEXOR, SINGLE, FINGER, OPEN, EACH					
261	26460	TENOTOMY, EXTENSOR, HAND OR FINGER, SINGLE, OPEN, EACH					
261	26471	TENODESIS; FOR PROXIMAL INTERPHALANGEAL JOINT STABILIZATION					
261	26474	TENODESIS; FOR DISTAL JOINT STABILIZATION					
261	26476	TENDON LENGTHENING, EXTENSOR, HAND OR FINGER, SINGLE, EACH					
261	26477	TENDON SHORTENING, EXTENSOR, HAND OR FINGER, SINGLE, EACH					
261	26478	TENDON LENGTHENING, FLEXOR, HAND OR FINGER, SINGLE, EACH					
261	26479	TENDON SHORTENING, FLEXOR, HAND OR FINGER, SINGLE, EACH					
261	26500	TENDON PULLEY RECONSTRUCTION; WITH LOCAL TISSUES (SEPARATE PROCEDURE)					
261	26508	THENAR MUSCLE RELEASE FOR THUMB CONTRACTURE					
261	26520	CAPSULECTOMY OR CAPSULOTOMY FOR CONTRACTURE; METACARPOPHALANGEAL JOINT, SINGLE, EACH					
261	26525	CAPSULECTOMY OR CAPSULOTOMY FOR CONTRACTURE; INTERPHALANGEAL JOINT, SINGLE, EACH					
261	26540	REPAIR OF COLLATERAL LIGAMENT, METACARPOPHALANGEAL OR INTERPHALANGEAL JOINT					
261	26542	RECONSTRUCTION, COLLATERAL LIGAMENT, METACARPOPHALANGEAL JOINT, SINGLE; WITH LOCAL TISSUE (EG, ADDUCTOR ADVANCEMENT)					
261	26560	REPAIR OF SYNDACTYLY (WEB FINGER) EACH WEB SPACE; WITH SKIN FLAPS					
261	26587	RECONSTRUCTION OF SUPERNUMERARY DIGIT, SOFT TISSUE AND BONE					
261	26593	RELEASE, INTRINSIC MUSCLES OF HAND (SPECIFY)					
261	26951	AMPUTATION, FINGER OR THUMB, PRIMARY OR SECONDARY, ANY JOINT OR PHALANX, SINGLE, INCLUDING NEURECTOMIES; WITH DIRECT CLOSURE					
261	26952	AMPUTATION, FINGER OR THUMB, PRIMARY OR SECONDARY, ANY JOINT OR PHALANX, SINGLE, INCLUDING NEURECTOMIES; WITH LOCAL ADVANCEMENT FLAPS (V–Y, HOOD)					
262	Level II Hand Musculoskeletal Procedures		T	18.35	$929.78	$480.82	$185.96
262	25210	CARPECTOMY; ONE BONE					
262	25215	CARPECTOMY; ALL BONES OF PROXIMAL ROW					
262	25825	INTERCARPAL FUSION; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT)					
262	26040	FASCIOTOMY, PALMAR, FOR DUPUYTREN'S CONTRACTURE; PERCUTANEOUS					
262	26045	FASCIOTOMY, PALMAR, FOR DUPUYTREN'S CONTRACTURE; OPEN, PARTIAL					
262	26121	FASCIECTOMY, PALM ONLY, WITH OR WITHOUT Z–PLASTY, OTHER LOCAL TISSUE REARRANGEMENT, OR SKIN GRAFTING (INCLUDES OBTAINING GRAFT)					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
262	26123	FASCIECTOMY, PARTIAL PALMAR WITH RELEASE OF SINGLE DIGIT INCLUDING PROXIMAL INTERPHALANGEAL JOINT, WITH OR WITHOUT Z–PLASTY, OTHER LOCAL TISSUE REARRANGEMENT, OR SKIN GRAFTING (INCLUDES OBTAINING GRAFT);					
262	26125	FASCIECTOMY, PARTIAL PALMAR WITH RELEASE OF SINGLE DIGIT INCLUDING PROXIMAL INTERPHALANGEAL JOINT, WITH OR WITHOUT Z-PLASTY, OTHER LOCAL TISSUE REARRANGEMENT, OR SKIN GRAFTING (INCLUDES OBTAINING GRAFT); EACH ADDITIONAL DIGIT (LIST SEPARATELY IN ADDITION					
262	26135	SYNOVECTOMY, METACARPOPHALANGEAL JOINT INCLUDING INTRINSIC RELEASE AND EXTENSOR HOOD RECONSTRUCTION, EACH DIGIT					
262	26205	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR OF METACARPAL; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT)					
262	26255	RADICAL RESECTION (OSTECTOMY) FOR TUMOR, METACARPAL; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT)					
262	26350	FLEXOR TENDON REPAIR OR ADVANCEMENT, SINGLE, NOT IN ''NO MAN'S LAND''; PRIMARY OR SECONDARY WITHOUT FREE GRAFT, EACH TENDON					
262	26352	FLEXOR TENDON REPAIR OR ADVANCEMENT, SINGLE, NOT IN ''NO MAN'S LAND''; SECONDARY WITH FREE GRAFT (INCLUDES OBTAINING GRAFT), EACH TENDON					
262	26356	FLEXOR TENDON REPAIR OR ADVANCEMENT, SINGLE, IN ''NO MAN'S LAND''; PRIMARY, EACH TENDON					
262	26357	FLEXOR TENDON REPAIR OR ADVANCEMENT, SINGLE, IN ''NO MAN'S LAND''; SECONDARY, EACH TENDON					
262	26358	FLEXOR TENDON REPAIR OR ADVANCEMENT, SINGLE, IN ''NO MAN'S LAND''; SECONDARY WITH FREE GRAFT (INCLUDES OBTAINING GRAFT), EACH TENDON					
262	26370	PROFUNDUS TENDON REPAIR OR ADVANCEMENT, WITH INTACT SUBLIMIS; PRIMARY					
262	26372	PROFUNDUS TENDON REPAIR OR ADVANCEMENT, WITH INTACT SUBLIMIS; SECONDARY WITH FREE GRAFT (INCLUDES OBTAINING GRAFT)					
262	26373	PROFUNDUS TENDON REPAIR OR ADVANCEMENT, WITH INTACT SUBLIMIS; SECONDARY WITHOUT FREE GRAFT					
262	26390	FLEXOR TENDON EXCISION, IMPLANTATION OF PLASTIC TUBE OR ROD FOR DELAYED TENDON GRAFT, HAND OR FINGER					
262	26392	REMOVAL OF TUBE OR ROD AND INSERTION OF FLEXOR TENDON GRAFT (INCLUDES OBTAINING GRAFT), HAND OR FINGER					
262	26412	EXTENSOR TENDON REPAIR, DORSUM OF HAND, SINGLE, PRIMARY OR SECONDARY; WITH FREE GRAFT (INCLUDES OBTAINING GRAFT), EACH TENDON					
262	26415	EXTENSOR TENDON EXCISION, IMPLANTATION OF PLASTIC TUBE OR ROD FOR DELAYED EXTENSOR TENDON GRAFT, HAND OR FINGER					
262	26416	REMOVAL OF TUBE OR ROD AND INSERTION OF EXTENSOR TENDON GRAFT (INCLUDES OBTAINING GRAFT), HAND OR FINGER					
262	26420	EXTENSOR TENDON REPAIR, DORSUM OF FINGER, SINGLE, PRIMARY OR SECONDARY; WITH FREE GRAFT (INCLUDES OBTAINING GRAFT) EACH TENDON					
262	26426	EXTENSOR TENDON REPAIR, CENTRAL SLIP REPAIR, SECONDARY (BOUTONNIERE DEFORMITY); USING LOCAL TISSUES					
262	26428	EXTENSOR TENDON REPAIR, CENTRAL SLIP REPAIR, SECONDARY (BOUTONNIERE DEFORMITY); WITH FREE GRAFT (INCLUDES OBTAINING GRAFT)					
262	26434	EXTENSOR TENDON REPAIR, DISTAL INSERTION (''MALLET FINGER''), OPEN, PRIMARY OR SECONDARY REPAIR; WITH FREE GRAFT (INCLUDES OBTAINING GRAFT)					
262	26442	TENOLYSIS, SIMPLE, FLEXOR TENDON; PALM AND FINGER, EACH TENDON					
262	26449	TENOLYSIS, COMPLEX, EXTENSOR TENDON, DORSUM OF HAND OR FINGER, INCLUDING HAND AND FOREARM					
262	26480	TENDON TRANSFER OR TRANSPLANT, CARPOMETACARPAL AREA OR DORSUM OF HAND, SINGLE; WITHOUT FREE GRAFT, EACH					
262	26483	TENDON TRANSFER OR TRANSPLANT, CARPOMETACARPAL AREA OR DORSUM OF HAND, SINGLE; WITH FREE TENDON GRAFT (INCLUDES OBTAINING GRAFT), EACH TENDON					
262	26485	TENDON TRANSFER OR TRANSPLANT, PALMAR, SINGLE, EACH TENDON; WITHOUT FREE TENDON GRAFT					
262	26489	TENDON TRANSFER OR TRANSPLANT, PALMAR, SINGLE, EACH TENDON; WITH FREE TENDON GRAFT (INCLUDES OBTAINING GRAFT), EACH TENDON					
262	26490	OPPONENSPLASTY; SUBLIMIS TENDON TRANSFER TYPE					
262	26492	OPPONENSPLASTY; TENDON TRANSFER WITH GRAFT (INCLUDES OBTAINING GRAFT)					
262	26494	OPPONENSPLASTY; HYPOTHENAR MUSCLE TRANSFER					
262	26496	OPPONENSPLASTY; OTHER METHODS					
262	26497	TENDON TRANSFER TO RESTORE INTRINSIC FUNCTION; RING AND SMALL FINGER					
262	26498	TENDON TRANSFER TO RESTORE INTRINSIC FUNCTION; ALL FOUR FINGERS					
262	26499	CORRECTION CLAW FINGER, OTHER METHODS					
262	26502	TENDON PULLEY RECONSTRUCTION; WITH TENDON OR FASCIAL GRAFT (INCLUDES OBTAINING GRAFT) (SEPARATE PROCEDURE)					
262	26504	TENDON PULLEY RECONSTRUCTION; WITH TENDON PROSTHESIS (SEPARATE PROCEDURE)					
262	26510	CROSS INTRINSIC TRANSFER					
262	26516	CAPSULODESIS FOR M-P JOINT STABILIZATION; SINGLE DIGIT					
262	26517	CAPSULODESIS FOR M-P JOINT STABILIZATION; TWO DIGITS					
262	26518	CAPSULODESIS FOR M-P JOINT STABILIZATION; THREE OR FOUR DIGITS					
262	26541	RECONSTRUCTION, COLLATERAL LIGAMENT, METACARPOPHALANGEAL JOINT, SINGLE; WITH TENDON OR FASCIAL GRAFT (INCLUDES OBTAINING GRAFT)					
262	26545	RECONSTRUCTION, COLLATERAL LIGAMENT, INTERPHALANGEAL JOINT, SINGLE, INCLUDING GRAFT, EACH JOINT					
262	26546	REPAIR NON-UNION, METACARPAL OR PHALANX, (INCLUDES OBTAINING BONE GRAFT WITH OR WITHOUT EXTERNAL OR INTERNAL FIXATION)					
262	26548	REPAIR AND RECONSTRUCTION, FINGER, VOLAR PLATE, INTERPHALANGEAL JOINT					
262	26550	POLLICIZATION OF A DIGIT					
262	26555	POSITIONAL CHANGE OF OTHER FINGER					
262	26561	REPAIR OF SYNDACTYLY (WEB FINGER) EACH WEB SPACE; WITH SKIN FLAPS AND GRAFTS					
262	26562	REPAIR OF SYNDACTYLY (WEB FINGER) EACH WEB SPACE; COMPLEX (EG, INVOLVING BONE, NAILS)					
262	26565	OSTEOTOMY FOR CORRECTION OF DEFORMITY; METACARPAL					
262	26567	OSTEOTOMY FOR CORRECTION OF DEFORMITY; PHALANX OF FINGER					
262	26568	OSTEOPLASTY FOR LENGTHENING OF METACARPAL OR PHALANX					
262	26580	REPAIR CLEFT HAND					
262	26585	REPAIR BIFID DIGIT					
262	26590	REPAIR MACRODACTYLIA					
262	26591	REPAIR, INTRINSIC MUSCLES OF HAND (SPECIFY)					
262	26596	EXCISION OF CONSTRICTING RING OF FINGER, WITH MULTIPLE Z-PLASTIES					
262	26597	RELEASE OF SCAR CONTRACTURE, FLEXOR OR EXTENSOR, WITH SKIN GRAFTS, REARRANGEMENT FLAPS, OR Z-PLASTIES, HAND AND/OR FINGER					

(See Addendum D. for Payment of Medical Visits)

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
262	26820	FUSION IN OPPOSITION, THUMB, WITH AUTOGENOUS GRAFT (INCLUDES OBTAINING GRAFT)					
262	26841	ARTHRODESIS, CARPOMETACARPAL JOINT, THUMB, WITH OR WITHOUT INTERNAL FIXATION;					
262	26842	ARTHRODESIS, CARPOMETACARPAL JOINT, THUMB, WITH OR WITHOUT INTERNAL FIXATION; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT)					
262	26843	ARTHRODESIS, CARPOMETACARPAL JOINT, DIGITS, OTHER THAN THUMB;					
262	26844	ARTHRODESIS, CARPOMETACARPAL JOINT, DIGITS, OTHER THAN THUMB; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT)					
262	26850	ARTHRODESIS, METACARPOPHALANGEAL JOINT, WITH OR WITHOUT INTERNAL FIXATION;					
262	26852	ARTHRODESIS, METACARPOPHALANGEAL JOINT, WITH OR WITHOUT INTERNAL FIXATION; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT)					
262	26860	ARTHRODESIS, INTERPHALANGEAL JOINT, WITH OR WITHOUT INTERNAL FIXATION;					
262	26861	ARTHRODESIS, INTERPHALANGEAL JOINT, WITH OR WITHOUT INTERNAL FIXATION; EACH ADDITIONAL INTERPHALANGEAL JOINT					
262	26862	ARTHRODESIS, INTERPHALANGEAL JOINT, WITH OR WITHOUT INTERNAL FIXATION; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT)					
262	26863	ARTHRODESIS, INTERPHALANGEAL JOINT, WITH OR WITHOUT INTERNAL FIXATION; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT), EACH ADDITIONAL JOINT					
262	26910	AMPUTATION, METACARPAL, WITH FINGER OR THUMB (RAY AMPUTATION), SINGLE, WITH OR WITHOUT INTEROSSEOUS TRANSFER					
271	Level I Foot Musculoskeletal Procedures		T	14.41	$730.15	$368.38	$146.03
271	27605	TENOTOMY, ACHILLES TENDON, SUBCUTANEOUS (SEPARATE PROCEDURE); *LOCAL ANESTHESIA					
271	28005	INCISION, DEEP, WITH OPENING OF BONE CORTEX (EG, FOR OSTEOMYELITIS OR BONE ABSCESS), FOOT					
271	28008	FASCIOTOMY, FOOT AND/OR TOE					
271	28010	TENOTOMY, SUBCUTANEOUS, TOE; SINGLE					
271	28011	TENOTOMY, SUBCUTANEOUS, TOE; MULTIPLE					
271	28020	ARTHROTOMY, WITH EXPLORATION, DRAINAGE, OR REMOVAL OF LOOSE OR FOREIGN BODY; INTERTARSAL OR TARSOMETATARSAL JOINT					
271	28022	ARTHROTOMY, WITH EXPLORATION, DRAINAGE, OR REMOVAL OF LOOSE OR FOREIGN BODY; METATARSOPHALANGEAL JOINT					
271	28024	ARTHROTOMY, WITH EXPLORATION, DRAINAGE, OR REMOVAL OF LOOSE OR FOREIGN BODY; INTERPHALANGEAL JOINT					
271	28045	EXCISION, TUMOR, FOOT; DEEP, SUBFASCIAL, INTRAMUSCULAR					
271	28046	RADICAL RESECTION OF TUMOR (EG, MALIGNANT NEOPLASM), SOFT TISSUE OF FOOT					
271	28050	ARTHROTOMY FOR SYNOVIAL BIOPSY; INTERTARSAL OR TARSOMETATARSAL JOINT					
271	28052	ARTHROTOMY FOR SYNOVIAL BIOPSY; METATARSOPHALANGEAL JOINT					
271	28054	ARTHROTOMY FOR SYNOVIAL BIOPSY; INTERPHALANGEAL JOINT					
271	28080	EXCISION OF INTERDIGITAL (MORTON) NEUROMA, SINGLE, EACH					
271	28086	SYNOVECTOMY, TENDON SHEATH, FOOT; FLEXOR					
271	28088	SYNOVECTOMY, TENDON SHEATH, FOOT; EXTENSOR					
271	28090	EXCISION OF LESION OF TENDON OR FIBROUS SHEATH OR CAPSULE (INCLUDING SYNOVECTOMY) (CYST OR GANGLION); FOOT					
271	28092	EXCISION OF LESION OF TENDON OR FIBROUS SHEATH OR CAPSULE (INCLUDING SYNOVECTOMY) (CYST OR GANGLION); TOES					
271	28100	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR, TALUS OR CALCANEUS;					
271	28104	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR, TARSAL OR METATARSAL BONES, EXCEPT TALUS OR CALCANEUS;					
271	28108	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR, PHALANGES OF FOOT					
271	28111	OSTECTOMY, COMPLETE EXCISION; FIRST METATARSAL HEAD					
271	28112	OSTECTOMY, COMPLETE EXCISION; OTHER METATARSAL HEAD (SECOND, THIRD OR FOURTH)					
271	28113	OSTECTOMY, COMPLETE EXCISION; FIFTH METATARSAL HEAD					
271	28114	OSTECTOMY, COMPLETE EXCISION; ALL METATARSAL HEADS, WITH PARTIAL PROXIMAL PHALANGECTOMY, EXCLUDING FIRST METATARSAL (CLAYTON TYPE PROCEDURE)					
271	28116	OSTECTOMY, EXCISION OF TARSAL COALITION					
271	28118	OSTECTOMY, CALCANEUS;					
271	28119	OSTECTOMY, CALCANEUS; FOR SPUR, WITH OR WITHOUT PLANTAR FASCIAL RELEASE					
271	28120	PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, SEQUESTRECTOMY, OR DIAPHYSECTOMY) OF BONE (EG, FOR OSTEOMYELITIS OR TALAR BOSSING), TALUS OR CALCANEUS					
271	28122	PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR DIAPHYSECTOMY) OF BONE (EG, FOR OSTEOMYELITIS OR TARSAL BOSSING), TARSAL OR METATARSAL BONE, EXCEPT TALUS OR CALCANEUS					
271	28124	PARTIAL EXCISION (CRATERIZATION, SAUCERIZATION, OR DIAPHYSECTOMY) OF BONE (EG, FOR OSTEOMYELITIS OR DORSAL BOSSING), PHALANX OF TOE					
271	28126	RESECTION, PARTIAL OR COMPLETE, PHALANGEAL BASE, SINGLE TOE, EACH					
271	28130	TALECTOMY (ASTRAGALECTOMY)					
271	28140	METATARSECTOMY					
271	28150	PHALANGECTOMY OF TOE, SINGLE, EACH					
271	28153	RESECTION, HEAD OF PHALANX, TOE					
271	28160	HEMIPHALANGECTOMY OR INTERPHALANGEAL JOINT EXCISION, TOE, SINGLE, EACH					
271	28171	RADICAL RESECTION OF TUMOR, BONE; TARSAL (EXCEPT TALUS OR CALCANEUS)					
271	28173	RADICAL RESECTION OF TUMOR, BONE; METATARSAL					
271	28175	RADICAL RESECTION OF TUMOR, BONE; PHALANX OF TOE					
271	28200	REPAIR OR SUTURE OF TENDON, FOOT, FLEXOR, SINGLE; PRIMARY OR SECONDARY, WITHOUT FREE GRAFT, EACH TENDON					
271	28208	REPAIR OR SUTURE OF TENDON, FOOT, EXTENSOR, SINGLE; PRIMARY OR SECONDARY, EACH TENDON					
271	28210	REPAIR OR SUTURE OF TENDON, FOOT, EXTENSOR, SINGLE; SECONDARY WITH FREE GRAFT, EACH TENDON (INCLUDES OBTAINING GRAFT)					
271	28220	TENOLYSIS, FLEXOR, FOOT; SINGLE					
271	28222	TENOLYSIS, FLEXOR, FOOT; MULTIPLE (THROUGH SAME INCISION)					
271	28225	TENOLYSIS, EXTENSOR, FOOT; SINGLE					
271	28226	TENOLYSIS, EXTENSOR, FOOT; MULTIPLE (THROUGH SAME INCISION)					
271	28230	TENOTOMY, OPEN, FLEXOR; FOOT, SINGLE OR MULTIPLE (SEPARATE PROCEDURE)					
271	28232	TENOTOMY, OPEN, FLEXOR; TOE, SINGLE (SEPARATE PROCEDURE)					
271	28234	TENOTOMY, OPEN, EXTENSOR, FOOT OR TOE					
271	28240	TENOTOMY, LENGTHENING, OR RELEASE, ABDUCTOR HALLUCIS MUSCLE					
271	28270	CAPSULOTOMY; METATARSOPHALANGEAL JOINT, WITH OR WITHOUT TENORRHAPHY, SINGLE, EACH JOINT (SEPARATE PROCEDURE)					

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
271	28272	CAPSULOTOMY; INTERPHALANGEAL JOINT, SINGLE, EACH JOINT (SEPARATE PROCEDURE)					
271	28280	WEBBING OPERATION (CREATE SYNDACTYLISM OF TOES) (KELIKIAN TYPE PROCEDURE)					
271	28285	HAMMERTOE OPERATION, ONE TOE (EG, INTERPHALANGEAL FUSION, FILLETING, PHALANGECTOMY)					
271	28286	COCK-UP FIFTH TOE OPERATION WITH PLASTIC SKIN CLOSURE (RUIZ-MORA TYPE PROCEDURE)					
271	28310	OSTEOTOMY FOR SHORTENING, ANGULAR OR ROTATIONAL CORRECTION; PROXIMAL PHALANX, FIRST TOE (SEPARATE PROCEDURE)					
271	28312	OSTEOTOMY FOR SHORTENING, ANGULAR OR ROTATIONAL CORRECTION; OTHER PHALANGES, ANY TOE					
271	28313	RECONSTRUCTION, ANGULAR DEFORMITY OF TOE (OVERLAPPING SECOND TOE, FIFTH TOE, CURLY TOES), SOFT TISSUE PROCEDURES ONLY					
271	28315	SESAMOIDECTOMY, FIRST TOE (SEPARATE PROCEDURE)					
271	28340	RECONSTRUCTION, TOE, MACRODACTYLY; SOFT TISSUE RESECTION					
271	28341	RECONSTRUCTION, TOE, MACRODACTYLY; REQUIRING BONE RESECTION					
271	28737	ARTHRODESIS, MIDTARSAL NAVICULAR-CUNEIFORM, WITH TENDON LENGTHENING AND ADVANCEMENT (MILLER TYPE PROCEDURE)					
271	28750	ARTHRODESIS, GREAT TOE; METATARSOPHALANGEAL JOINT					
271	28755	ARTHRODESIS, GREAT TOE; INTERPHALANGEAL JOINT					
271	28810	AMPUTATION, METATARSAL, WITH TOE, SINGLE					
271	28820	AMPUTATION, TOE; METATARSOPHALANGEAL JOINT					
271	28825	AMPUTATION, TOE; INTERPHALANGEAL JOINT					
271	29893	ENDOSCOPIC PLANTAR FASCIOTOMY					
272	Level II Foot Musculoskeletal Procedures		T	16.56	$839.09	$409.74	$167.82
272	28060	FASCIECTOMY, EXCISION OF PLANTAR FASCIA; PARTIAL (SEPARATE PROCEDURE)					
272	28062	FASCIECTOMY, EXCISION OF PLANTAR FASCIA; RADICAL (SEPARATE PROCEDURE)					
272	28070	SYNOVECTOMY; INTERTARSAL OR TARSOMETATARSAL JOINT, EACH					
272	28072	SYNOVECTOMY; METATARSOPHALANGEAL JOINT, EACH					
272	28102	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR, TALUS OR CALCANEUS; WITH ILIAC OR OTHER AUTOGRAFT (INCLUDES OBTAINING GRAFT)					
272	28103	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR, TALUS OR CALCANEUS; WITH ALLOGRAFT					
272	28106	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR, TARSAL OR METATARSAL BONES, EXCEPT TALUS OR CALCANEUS; WITH ILIAC OR OTHER AUTOGRAFT (INCLUDES OBTAINING GRAFT)					
272	28107	EXCISION OR CURETTAGE OF BONE CYST OR BENIGN TUMOR, TARSAL OR METATARSAL BONES, EXCEPT TALUS OR CALCANEUS; WITH ALLOGRAFT					
272	28202	REPAIR OR SUTURE OF TENDON, FOOT, FLEXOR, SINGLE; SECONDARY WITH FREE GRAFT, EACH TENDON (INCLUDES OBTAINING GRAFT)					
272	28238	ADVANCEMENT OF POSTERIOR TIBIAL TENDON WITH EXCISION OF ACCESSORY NAVICULAR BONE (KIDNER TYPE PROCEDURE)					
272	28250	DIVISION OF PLANTAR FASCIA AND MUSCLE (''STEINDLER STRIPPING'') (SEPARATE PROCEDURE)					
272	28260	CAPSULOTOMY, MIDFOOT; MEDIAL RELEASE ONLY (SEPARATE PROCEDURE)					
272	28261	CAPSULOTOMY, MIDFOOT; WITH TENDON LENGTHENING					
272	28262	CAPSULOTOMY, MIDFOOT; EXTENSIVE, INCLUDING POSTERIOR TALOTIBIAL CAPSULOTOMY AND TENDON(S) LENGTHENING AS FOR RESISTANT CLUBFOOT DEFORMITY					
272	28264	CAPSULOTOMY, MIDTARSAL (HEYMAN TYPE PROCEDURE)					
272	28288	OSTECTOMY, PARTIAL, EXOSTECTOMY OR CONDYLECTOMY, SINGLE, METATARSAL HEAD, FIRST THROUGH FIFTH, EACH METATARSAL HEAD					
272	28300	OSTEOTOMY; CALCANEUS (DWYER OR CHAMBERS TYPE PROCEDURE), WITH OR WITHOUT INTERNAL FIXATION					
272	28302	OSTEOTOMY; TALUS					
272	28304	OSTEOTOMY, MIDTARSAL BONES, OTHER THAN CALCANEUS OR TALUS;					
272	28305	OSTEOTOMY, MIDTARSAL BONES, OTHER THAN CALCANEUS OR TALUS; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT) (FOWLER TYPE)					
272	28306	OSTEOTOMY, METATARSAL, BASE OR SHAFT, SINGLE, WITH OR WITHOUT LENGTHENING, FOR SHORTENING OR ANGULAR CORRECTION; FIRST METATARSAL					
272	28307	OSTEOTOMY, METATARSAL, BASE OR SHAFT, SINGLE, WITH OR WITHOUT LENGTHENING, FOR SHORTENING OR ANGULAR CORRECTION; FIRST METATARSAL WITH AUTOGRAFT					
272	28308	OSTEOTOMY, METATARSAL, BASE OR SHAFT, SINGLE, WITH OR WITHOUT LENGTHENING, FOR SHORTENING OR ANGULAR CORRECTION; OTHER THAN FIRST METATARSAL					
272	28309	OSTEOTOMY, METATARSALS, MULTIPLE, FOR CAVUS FOOT (SWANSON TYPE PROCEDURE)					
272	28320	REPAIR OF NONUNION OR MALUNION; TARSAL BONES (EG, CALCANEUS, TALUS)					
272	28322	REPAIR OF NONUNION OR MALUNION; METATARSAL, WITH OR WITHOUT BONE GRAFT (INCLUDES OBTAINING GRAFT)					
272	28344	RECONSTRUCTION, TOE(S); POLYDACTYLY					
272	28345	RECONSTRUCTION, TOE(S); SYNDACTYLY, WITH OR WITHOUT SKIN GRAFT(S), EACH WEB					
272	28360	RECONSTRUCTION, CLEFT FOOT					
272	28705	PANTALAR ARTHRODESIS					
272	28715	TRIPLE ARTHRODESIS					
272	28725	SUBTALAR ARTHRODESIS					
272	28730	ARTHRODESIS, MIDTARSAL OR TARSOMETATARSAL, MULTIPLE OR TRANSVERSE;					
272	28735	ARTHRODESIS, MIDTARSAL OR TARSOMETATARSAL, MULTIPLE OR TRANSVERSE; WITH OSTEOTOMY AS FOR FLATFOOT CORRECTION					
272	28740	ARTHRODESIS, MIDTARSAL OR TARSOMETATARSAL, SINGLE JOINT					
272	28760	ARTHRODESIS, GREAT TOE, INTERPHALANGEAL JOINT, WITH EXTENSOR HALLUCIS LONGUS TRANSFER TO FIRST METATARSAL NECK (JONES TYPE PROCEDURE)					
276	Bunion Procedures		T	19.19	$972.35	$500.14	$194.47
276	28110	OSTECTOMY, PARTIAL EXCISION, FIFTH METATARSAL HEAD (BUNIONETTE) (SEPARATE PROCEDURE)					
276	28290	HALLUX VALGUS (BUNION) CORRECTION, WITH OR WITHOUT SESAMOIDECTOMY; SIMPLE EXOSTECTOMY (SILVER TYPE PROCEDURE)					
276	28292	HALLUX VALGUS (BUNION) CORRECTION, WITH OR WITHOUT SESAMOIDECTOMY; KELLER, MCBRIDE, OR MAYO TYPE PROCEDURE					
276	28293	HALLUX VALGUS (BUNION) CORRECTION, WITH OR WITHOUT SESAMOIDECTOMY; RESECTION OF JOINT WITH IMPLANT					

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
276	28294	HALLUX VALGUS (BUNION) CORRECTION, WITH OR WITHOUT SESAMOIDECTOMY; WITH TENDON TRANSPLANTS (JOPLIN TYPE PROCEDURE)					
276	28296	HALLUX VALGUS (BUNION) CORRECTION, WITH OR WITHOUT SESAMOIDECTOMY; WITH METATARSAL OSTEOTOMY (EG, MITCHELL, CHEVRON, OR CONCENTRIC TYPE PROCEDURES)					
276	28297	HALLUX VALGUS (BUNION) CORRECTION, WITH OR WITHOUT SESAMOIDECTOMY; LAPIDUS TYPE PROCEDURE					
276	28298	HALLUX VALGUS (BUNION) CORRECTION, WITH OR WITHOUT SESAMOIDECTOMY; BY PHALANX OSTEOTOMY					
276	28299	HALLUX VALGUS (BUNION) CORRECTION, WITH OR WITHOUT SESAMOIDECTOMY; BY OTHER METHODS (EG, DOUBLE OSTEOTOMY)					
280	Diagnostic Arthroscopy		T	22.2	$1,124.86	$581.72	$224.97
280	29800	ARTHROSCOPY, TEMPOROMANDIBULAR JOINT, DIAGNOSTIC, WITH OR WITHOUT SYNOVIAL BIOPSY (SEPARATE PROCEDURE)					
280	29815	ARTHROSCOPY, SHOULDER, DIAGNOSTIC, WITH OR WITHOUT SYNOVIAL BIOPSY (SEPARATE PROCEDURE)					
280	29830	ARTHROSCOPY, ELBOW, DIAGNOSTIC, WITH OR WITHOUT SYNOVIAL BIOPSY (SEPARATE PROCEDURE)					
280	29840	ARTHROSCOPY, WRIST, DIAGNOSTIC, WITH OR WITHOUT SYNOVIAL BIOPSY (SEPARATE PROCEDURE)					
280	29870	ARTHROSCOPY, KNEE, DIAGNOSTIC, WITH OR WITHOUT SYNOVIAL BIOPSY (SEPARATE PROCEDURE)					
280	29909	UNLISTED PROCEDURE, ARTHROSCOPY					
281	Level I Surgical Arthroscopy		T	22.65	$1,147.66	$590.20	$229.53
281	29804	ARTHROSCOPY, TEMPOROMANDIBULAR JOINT, SURGICAL					
281	29819	ARTHROSCOPY, SHOULDER, SURGICAL; WITH REMOVAL OF LOOSE BODY OR FOREIGN BODY					
281	29820	ARTHROSCOPY, SHOULDER, SURGICAL; SYNOVECTOMY, PARTIAL					
281	29821	ARTHROSCOPY, SHOULDER, SURGICAL; SYNOVECTOMY, COMPLETE					
281	29822	ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, LIMITED					
281	29823	ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT, EXTENSIVE					
281	29825	ARTHROSCOPY, SHOULDER, SURGICAL; WITH LYSIS AND RESECTION OF ADHESIONS, WITH OR WITHOUT MANIPULATION					
281	29826	ARTHROSCOPY, SHOULDER, SURGICAL; DECOMPRESSION OF SUBACROMIAL SPACE WITH PARTIAL ACROMIOPLASTY, WITH OR WITHOUT CORACOACROMIAL RELEASE					
281	29834	ARTHROSCOPY, ELBOW, SURGICAL; WITH REMOVAL OF LOOSE BODY OR FOREIGN BODY					
281	29835	ARTHROSCOPY, ELBOW, SURGICAL; SYNOVECTOMY, PARTIAL					
281	29836	ARTHROSCOPY, ELBOW, SURGICAL; SYNOVECTOMY, COMPLETE					
281	29837	ARTHROSCOPY, ELBOW, SURGICAL; DEBRIDEMENT, LIMITED					
281	29838	ARTHROSCOPY, ELBOW, SURGICAL; DEBRIDEMENT, EXTENSIVE					
281	29843	ARTHROSCOPY, WRIST, SURGICAL; FOR INFECTION, LAVAGE AND DRAINAGE					
281	29844	ARTHROSCOPY, WRIST, SURGICAL; SYNOVECTOMY, PARTIAL					
281	29845	ARTHROSCOPY, WRIST, SURGICAL; SYNOVECTOMY, COMPLETE					
281	29846	ARTHROSCOPY, WRIST, SURGICAL; EXCISION AND/OR REPAIR OF TRIANGULAR FIBROCARTILAGE AND/OR JOINT DEBRIDEMENT					
281	29847	ARTHROSCOPY, WRIST, SURGICAL; INTERNAL FIXATION FOR FRACTURE OR INSTABILITY					
281	29848	ARTHROSCOPY, WRIST, SURGICAL; WITH RELEASE OF TRANSVERSE CARPAL LIGAMENT					
281	29860	ARTHROSCOPY, HIP, DIAGNOSTIC WITH OR WITHOUT SYNOVIAL BIOPSY (SEPARATE PROCEDURE)					
281	29861	ARTHROSCOPY, HIP, SURGICAL; WITH REMOVAL OF LOOSE BODY OR FOREIGN BODY					
281	29862	ARTHROSCOPY, HIP, SURGICAL; WITH DEBRIDEMENT/SHAVING OF ARTICULAR CARTILAGE (CHONDROPLASTY), ABRASION ARTHROPLASTY, AND/OR RESECTION OF LABRUM					
281	29863	ARTHROSCOPY, HIP, SURGICAL; WITH SYNOVECTOMY					
281	29874	ARTHROSCOPY, KNEE, SURGICAL; FOR REMOVAL OF LOOSE BODY OR FOREIGN BODY (EG, OSTEOCHONDRITIS DISSECANS FRAGMENTATION, CHONDRAL FRAGMENTATION)					
281	29875	ARTHROSCOPY, KNEE, SURGICAL; SYNOVECTOMY, LIMITED (EG, PLICA OR SHELF RESECTION) (SEPARATE PROCEDURE)					
281	29877	ARTHROSCOPY, KNEE, SURGICAL; DEBRIDEMENT/SHAVING OF ARTICULAR CARTILAGE (CHONDROPLASTY)					
281	29879	ARTHROSCOPY, KNEE, SURGICAL; ABRASION ARTHROPLASTY (INCLUDES CHONDROPLASTY WHERE NECESSARY) OR MULTIPLE DRILLING					
281	29880	ARTHROSCOPY, KNEE, SURGICAL; WITH MENISCECTOMY (MEDIAL AND LATERAL, INCLUDING ANY MENISCAL SHAVING)					
281	29881	ARTHROSCOPY, KNEE, SURGICAL; WITH MENISCECTOMY (MEDIAL OR LATERAL, INCLUDING ANY MENISCAL SHAVING)					
281	29884	ARTHROSCOPY, KNEE, SURGICAL; WITH LYSIS OF ADHESIONS, WITH OR WITHOUT MANIPULATION (SEPARATE PROCEDURE)					
281	29886	ARTHROSCOPY, KNEE, SURGICAL; DRILLING FOR INTACT OSTEOCHONDRITIS DISSECANS LESION					
281	29894	ARTHROSCOPY, ANKLE (TIBIOTALAR AND FIBULOTALAR JOINTS), SURGICAL; WITH REMOVAL OF LOOSE BODY OR FOREIGN BODY					
281	29895	ARTHROSCOPY, ANKLE (TIBIOTALAR AND FIBULOTALAR JOINTS), SURGICAL; SYNOVECTOMY, PARTIAL					
281	29897	ARTHROSCOPY, ANKLE (TIBIOTALAR AND FIBULOTALAR JOINTS), SURGICAL; DEBRIDEMENT, LIMITED					
281	29898	ARTHROSCOPY, ANKLE (TIBIOTALAR AND FIBULOTALAR JOINTS), SURGICAL; DEBRIDEMENT, EXTENSIVE					
282	Level II Surgical Arthroscopy		T	23.94	$1,213.03	$614.04	$242.61
282	29871	ARTHROSCOPY, KNEE, SURGICAL; FOR INFECTION, LAVAGE AND DRAINAGE					
282	29876	ARTHROSCOPY, KNEE, SURGICAL; SYNOVECTOMY, MAJOR, TWO OR MORE COMPARTMENTS (EG, MEDIAL OR LATERAL)					
282	29882	ARTHROSCOPY, KNEE, SURGICAL; WITH MENISCUS REPAIR (MEDIAL OR LATERAL)					
282	29883	ARTHROSCOPY, KNEE, SURGICAL; WITH MENISCUS REPAIR (MEDIAL AND LATERAL)					
282	29885	ARTHROSCOPY, KNEE, SURGICAL; DRILLING FOR OSTEOCHONDRITIS DISSECANS WITH BONE GRAFTING, WITH OR WITHOUT INTERNAL FIXATION (INCLUDING DEBRIDEMENT OF BASE OF LESION)					
282	29887	ARTHROSCOPY, KNEE, SURGICAL; DRILLING FOR INTACT OSTEOCHONDRITIS DISSECANS LESION WITH INTERNAL FIXATION					
282	29891	ARTHROSCOPY, ANKLE, SURGICAL; EXCISION OF OSTEOCHONDRAL DEFECT OF TALUS AND/OR TIBIA, INCLUDING DRILLING OF THE DEFECT					
286	Arthroscopically-Aided Procedures		T	26.76	$1,355.91	$802.41	$271.18
286	29850	ARTHROSCOPICALLY AIDED TREATMENT OF INTERCONDYLAR SPINE(S) AND/OR TUBEROSITY FRACTURE(S) OF THE KNEE, WITH OR WITHOUT MANIPULATION; WITHOUT INTERNAL OR EXTERNAL FIXATION (INCLUDES ARTHROSCOPY)					
286	29851	ARTHROSCOPICALLY AIDED TREATMENT OF INTERCONDYLAR SPINE(S) AND/OR TUBEROSITY FRACTURE(S) OF THE KNEE, WITH OR WITHOUT MANIPULATION; WITH INTERNAL OR EXTERNAL FIXATION (INCLUDES ARTHROSCOPY)					
286	29855	ARTHROSCOPICALLY AIDED TREATMENT OF TIBIAL FRACTURE, PROXIMAL (PLATEAU); UNICONDYLAR, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION (INCLUDES ARTHROSCOPY)					
286	29856	ARTHROSCOPICALLY AIDED TREATMENT OF TIBIAL FRACTURE, PROXIMAL (PLATEAU); BICONDYLAR, WITH OR WITHOUT INTERNAL OR EXTERNAL FIXATION (INCLUDES ARTHROSCOPY)					

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
286	29888	ARTHROSCOPICALLY AIDED ANTERIOR CRUCIATE LIGAMENT REPAIR/AUGMENTATION OR RECONSTRUCTION					
286	29889	ARTHROSCOPICALLY AIDED POSTERIOR CRUCIATE LIGAMENT REPAIR/ AUGMENTATION OR RECONSTRUCTION					
286	29892	ARTHROSCOPICALLY AIDED REPAIR OF LARGE OSTEOCHONDRITIS DISSECANS LESION, TALAR DOME FRACTURE, OR TIBIAL PLAFOND FRACTURE, WITH OR WITHOUT INTERNAL FIXATION (INCLUDES ARTHROSCOPY)					
311	Level I ENT Procedures		T	1.43	$72.46	$20.57	$14.49
311	30000	DRAINAGE ABSCESS OR HEMATOMA, NASAL, INTERNAL APPROACH					
311	30020	DRAINAGE ABSCESS OR HEMATOMA, NASAL SEPTUM					
311	30100	BIOPSY, INTRANASAL					
311	30110	EXCISION, NASAL POLYP(S), SIMPLE					
311	30117	EXCISION OR DESTRUCTION, ANY METHOD (INCLUDING LASER), INTRANASAL LESION; INTERNAL APPROACH					
311	30124	EXCISION DERMOID CYST, NOSE; SIMPLE, SKIN, SUBCUTANEOUS					
311	30210	DISPLACEMENT THERAPY (PROETZ TYPE)					
311	30220	INSERTION, NASAL SEPTAL PROSTHESIS (BUTTON)					
311	30300	REMOVAL FOREIGN BODY, INTRANASAL; OFFICE TYPE PROCEDURE					
311	30560	LYSIS INTRANASAL SYNECHIA					
311	31000	LAVAGE BY CANNULATION; MAXILLARY SINUS (ANTRUM PUNCTURE OR NATURAL OSTIUM)					
311	31002	LAVAGE BY CANNULATION; SPHENOID SINUS					
311	31603	TRACHEOSTOMY, EMERGENCY PROCEDURE; TRANSTRACHEAL					
311	31605	TRACHEOSTOMY, EMERGENCY PROCEDURE; CRICOTHYROID MEMBRANE					
311	40490	BIOPSY OF LIP					
311	40799	UNLISTED PROCEDURE, LIPS					
311	40800	DRAINAGE OF ABSCESS, CYST, HEMATOMA, VESTIBULE OF MOUTH; SIMPLE					
311	40801	DRAINAGE OF ABSCESS, CYST, HEMATOMA, VESTIBULE OF MOUTH; COMPLICATED					
311	40804	REMOVAL OF EMBEDDED FOREIGN BODY, VESTIBULE OF MOUTH; SIMPLE					
311	40805	REMOVAL OF EMBEDDED FOREIGN BODY, VESTIBULE OF MOUTH; COMPLICATED					
311	40806	INCISION OF LABIAL FRENUM (FRENOTOMY)					
311	40808	BIOPSY, VESTIBULE OF MOUTH					
311	40810	EXCISION OF LESION OF MUCOSA AND SUBMUCOSA, VESTIBULE OF MOUTH; WITHOUT REPAIR					
311	40812	EXCISION OF LESION OF MUCOSA AND SUBMUCOSA, VESTIBULE OF MOUTH; WITH SIMPLE REPAIR					
311	40820	DESTRUCTION OF LESION OR SCAR OF VESTIBULE OF MOUTH BY PHYSICAL METHODS (EG, LASER, THERMAL, CRYO, CHEMICAL)					
311	40899	UNLISTED PROCEDURE, VESTIBULE OF MOUTH					
311	41000	INTRAORAL INCISION AND DRAINAGE OF ABSCESS, CYST, OR HEMATOMA OF TONGUE OR FLOOR OF MOUTH; LINGUAL					
311	41005	INTRAORAL INCISION AND DRAINAGE OF ABSCESS, CYST, OR HEMATOMA OF TONGUE OR FLOOR OF MOUTH; SUBLINGUAL, SUPERFICIAL					
311	41100	BIOPSY OF TONGUE; ANTERIOR TWO-THIRDS					
311	41105	BIOPSY OF TONGUE; POSTERIOR ONE-THIRD					
311	41108	BIOPSY OF FLOOR OF MOUTH					
311	41110	EXCISION OF LESION OF TONGUE WITHOUT CLOSURE					
311	41115	EXCISION OF LINGUAL FRENUM (FRENECTOMY)					
311	41599	UNLISTED PROCEDURE, TONGUE, FLOOR OF MOUTH					
311	41805	REMOVAL OF EMBEDDED FOREIGN BODY FROM DENTOALVEOLAR STRUCTURES; SOFT TISSUES					
311	41806	REMOVAL OF EMBEDDED FOREIGN BODY FROM DENTOALVEOLAR STRUCTURES; BONE					
311	41820	GINGIVECTOMY, EXCISION GINGIVA, EACH QUADRANT					
311	41821	OPERCULECTOMY, EXCISION PERICORONAL TISSUES					
311	41825	EXCISION OF LESION OR TUMOR (EXCEPT LISTED ABOVE), DENTOALVEOLAR STRUCTURES; WITHOUT REPAIR					
311	41826	EXCISION OF LESION OR TUMOR (EXCEPT LISTED ABOVE), DENTOALVEOLAR STRUCTURES; WITH SIMPLE REPAIR					
311	41828	EXCISION OF HYPERPLASTIC ALVEOLAR MUCOSA, EACH QUADRANT (SPECIFY)					
311	41830	ALVEOLECTOMY, INCLUDING CURETTAGE OF OSTEITIS OR SEQUESTRECTOMY					
311	41850	DESTRUCTION OF LESION (EXCEPT EXCISION), DENTOALVEOLAR STRUCTURES					
311	41870	PERIODONTAL MUCOSAL GRAFTING					
311	41872	GINGIVOPLASTY, EACH QUADRANT (SPECIFY)					
311	41874	ALVEOLOPLASTY, EACH QUADRANT (SPECIFY)					
311	41899	UNLISTED PROCEDURE, DENTOALVEOLAR STRUCTURES					
311	42000	DRAINAGE OF ABSCESS OF PALATE, UVULA					
311	42100	BIOPSY OF PALATE, UVULA					
311	42104	EXCISION, LESION OF PALATE, UVULA; WITHOUT CLOSURE					
311	42106	EXCISION, LESION OF PALATE, UVULA; WITH SIMPLE PRIMARY CLOSURE					
311	42140	UVULECTOMY, EXCISION OF UVULA					
311	42160	DESTRUCTION OF LESION, PALATE OR UVULA (THERMAL, CRYO OR CHEMICAL)					
311	42280	MAXILLARY IMPRESSION FOR PALATAL PROSTHESIS					
311	42281	INSERTION OF PIN-RETAINED PALATAL PROSTHESIS					
311	42299	UNLISTED PROCEDURE, PALATE, UVULA					
311	42330	SIALOLITHOTOMY; SUBMANDIBULAR (SUBMAXILLARY), SUBLINGUAL OR PAROTID, UNCOMPLICATED, INTRAORAL					
311	42335	SIALOLITHOTOMY; SUBMANDIBULAR (SUBMAXILLARY), COMPLICATED, INTRAORAL					
311	42650	DILATION SALIVARY DUCT					
311	42660	DILATION AND CATHETERIZATION OF SALIVARY DUCT, WITH OR WITHOUT INJECTION					
311	42665	LIGATION SALIVARY DUCT, INTRAORAL					
311	42699	UNLISTED PROCEDURE, SALIVARY GLANDS OR DUCTS					
311	69200	REMOVAL FOREIGN BODY FROM EXTERNAL AUDITORY CANAL; WITHOUT GENERAL ANESTHESIA					
311	69210	REMOVAL IMPACTED CERUMEN (SEPARATE PROCEDURE), ONE OR BOTH EARS					
311	69222	DEBRIDEMENT, MASTOIDECTOMY CAVITY, COMPLEX (EG, WITH ANESTHESIA OR MORE THAN ROUTINE CLEANING)					
311	69399	UNLISTED PROCEDURE, EXTERNAL EAR					
311	69400	EUSTACHIAN TUBE INFLATION, TRANSNASAL; WITH CATHETERIZATION					
311	69405	EUSTACHIAN TUBE CATHETERIZATION, TRANSTYMPANIC					
311	69410	FOCAL APPLICATION OF PHASE CONTROL SUBSTANCE, MIDDLE EAR (BAFFLE TECHNIQUE)					

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
311	69420	MYRINGOTOMY INCLUDING ASPIRATION AND/OR EUSTACHIAN TUBE INFLATION					
311	69424	VENTILATING TUBE REMOVAL WHEN ORIGINALLY INSERTED BY ANOTHER PHYSICIAN					
311	69540	EXCISION AURAL POLYP					
311	69610	TYMPANIC MEMBRANE REPAIR, WITH OR WITHOUT SITE PREPARATION OR PERFORATION FOR CLOSURE, WITH OR WITHOUT PATCH					
311	69799	UNLISTED PROCEDURE, MIDDLE EAR					
311	92502	OTOLARYNGOLOGIC EXAMINATION UNDER GENERAL ANESTHESIA					
312	Level II ENT Procedures		T	7.26	$367.86	$178.31	$73.57
312	30801	CAUTERIZATION AND/OR ABLATION, MUCOSA OF TURBINATES, UNILATERAL OR BILATERAL, ANY METHOD, (SEPARATE PROCEDURE); SUPERFICIAL					
312	30802	CAUTERIZATION AND/OR ABLATION, MUCOSA OF TURBINATES, UNILATERAL OR BILATERAL, ANY METHOD, (SEPARATE PROCEDURE); INTRAMURAL					
312	30930	FRACTURE NASAL TURBINATE(S), THERAPEUTIC					
312	31612	TRACHEAL PUNCTURE, PERCUTANEOUS WITH TRANSTRACHEAL ASPIRATION AND/OR INJECTION					
12	40830	CLOSURE OF LACERATION, VESTIBULE OF MOUTH; 2.5 CM OR LESS					
312	40831	CLOSURE OF LACERATION, VESTIBULE OF MOUTH; OVER 2.5 CM OR COMPLEX					
312	41250	REPAIR OF LACERATION 2.5 CM OR LESS; FLOOR OF MOUTH AND/OR ANTERIOR TWO-THIRDS OF TONGUE					
312	41251	REPAIR OF LACERATION 2.5 CM OR LESS; POSTERIOR ONE-THIRD OF TONGUE					
312	41252	REPAIR OF LACERATION OF TONGUE, FLOOR OF MOUTH, OVER 2.6 CM OR COMPLEX					
312	41500	FIXATION OF TONGUE, MECHANICAL, OTHER THAN SUTURE (EG, K-WIRE)					
312	41510	SUTURE OF TONGUE TO LIP FOR MICROGNATHIA (DOUGLAS TYPE PROCEDURE)					
312	41800	DRAINAGE OF ABSCESS, CYST, HEMATOMA FROM DENTOALVEOLAR STRUCTURES					
312	42300	DRAINAGE OF ABSCESS; PAROTID, SIMPLE					
312	42305	DRAINAGE OF ABSCESS; PAROTID, COMPLICATED					
312	42310	DRAINAGE OF ABSCESS; SUBMAXILLARY OR SUBLINGUAL, INTRAORAL					
312	42320	DRAINAGE OF ABSCESS; SUBMAXILLARY, EXTERNAL					
312	42405	BIOPSY OF SALIVARY GLAND; INCISIONAL					
312	42700	INCISION AND DRAINAGE ABSCESS; PERITONSILLAR					
312	42720	INCISION AND DRAINAGE ABSCESS; RETROPHARYNGEAL OR PARAPHARYNGEAL, INTRAORAL APPROACH					
312	42800	BIOPSY; OROPHARYNX					
312	42802	BIOPSY; HYPOPHARYNX					
312	42804	BIOPSY; NASOPHARYNX, VISIBLE LESION, SIMPLE					
312	42806	BIOPSY; NASOPHARYNX, SURVEY FOR UNKNOWN PRIMARY LESION					
312	42808	EXCISION OR DESTRUCTION OF LESION OF PHARYNX, ANY METHOD					
312	60000	INCISION AND DRAINAGE OF THYROGLOSSAL CYST, INFECTED					
312	69421	MYRINGOTOMY INCLUDING ASPIRATION AND/OR EUSTACHIAN TUBE INFLATION REQUIRING GENERAL ANESTHESIA					
312	69433	TYMPANOSTOMY (REQUIRING INSERTION OF VENTILATING TUBE), LOCAL OR TOPICAL ANESTHESIA					
312	69436	TYMPANOSTOMY (REQUIRING INSERTION OF VENTILATING TUBE), GENERAL ANESTHESIA					
313	Level III ENT Procedures		T	15.81	$801.08	$411.09	$160.22
313	30115	EXCISION, NASAL POLYP(S), EXTENSIVE					
313	30118	EXCISION OR DESTRUCTION, ANY METHOD (INCLUDING LASER), INTRANASAL LESION; EXTERNAL APPROACH (LATERAL RHINOTOMY)					
313	30120	EXCISION OR SURGICAL PLANING OF SKIN OF NOSE FOR RHINOPHYMA					
313	30125	EXCISION DERMOID CYST, NOSE; COMPLEX, UNDER BONE OR CARTILAGE					
313	30130	EXCISION TURBINATE, PARTIAL OR COMPLETE					
313	30140	SUBMUCOUS RESECTION TURBINATE, PARTIAL OR COMPLETE					
313	30150	RHINECTOMY; PARTIAL					
313	30160	RHINECTOMY; TOTAL					
313	30310	REMOVAL FOREIGN BODY, INTRANASAL; REQUIRING GENERAL ANESTHESIA					
313	30320	REMOVAL FOREIGN BODY, INTRANASAL; BY LATERAL RHINOTOMY					
313	30430	RHINOPLASTY, SECONDARY; MINOR REVISION (SMALL AMOUNT OF NASAL TIP WORK)					
313	30520	SEPTOPLASTY OR SUBMUCOUS RESECTION, WITH OR WITHOUT CARTILAGE SCORING, CONTOURING OR REPLACEMENT WITH GRAFT					
313	30540	REPAIR CHOANAL ATRESIA; INTRANASAL					
313	30580	REPAIR FISTULA; OROMAXILLARY (COMBINE WITH 31030 IF ANTROTOMY IS INCLUDED)					
313	30600	REPAIR FISTULA; ORONASAL					
313	30620	SEPTAL OR OTHER INTRANASAL DERMATOPLASTY (DOES NOT INCLUDE OBTAINING GRAFT)					
313	30630	REPAIR NASAL SEPTAL PERFORATIONS					
313	31020	SINUSOTOMY, MAXILLARY (ANTROTOMY); INTRANASAL					
313	31030	SINUSOTOMY, MAXILLARY (ANTROTOMY); RADICAL (CALDWELL-LUC) WITHOUT REMOVAL OF ANTROCHOANAL POLYPS					
313	31032	SINUSOTOMY, MAXILLARY (ANTROTOMY); RADICAL (CALDWELL-LUC) WITH REMOVAL OF ANTROCHOANAL POLYPS					
313	31050	SINUSOTOMY, SPHENOID, WITH OR WITHOUT BIOPSY;					
313	31051	SINUSOTOMY, SPHENOID, WITH OR WITHOUT BIOPSY; WITH MUCOSAL STRIPPING OR REMOVAL OF POLYP(S)					
313	31070	SINUSOTOMY FRONTAL; EXTERNAL, SIMPLE (TREPHINE OPERATION)					
313	31200	ETHMOIDECTOMY; INTRANASAL, ANTERIOR					
313	31320	LARYNGOTOMY (THYROTOMY, LARYNGOFISSURE); DIAGNOSTIC					
313	31595	SECTION RECURRENT LARYNGEAL NERVE, THERAPEUTIC (SEPARATE PROCEDURE), UNILATERAL					
313	31611	CONSTRUCTION OF TRACHEOESOPHAGEAL FISTULA AND SUBSEQUENT INSERTION OF AN ALARYNGEAL SPEECH PROSTHESIS (EG, VOICE BUTTON, BLOM-SINGER PROSTHESIS)					
313	31613	TRACHEOSTOMA REVISION; SIMPLE, WITHOUT FLAP ROTATION					
313	31614	TRACHEOSTOMA REVISION; COMPLEX, WITH FLAP ROTATION					
313	31820	SURGICAL CLOSURE TRACHEOSTOMY OR FISTULA; WITHOUT PLASTIC REPAIR					
313	31825	SURGICAL CLOSURE TRACHEOSTOMY OR FISTULA; WITH PLASTIC REPAIR					
313	31830	REVISION OF TRACHEOSTOMY SCAR					
313	40500	VERMILIONECTOMY (LIP SHAVE), WITH MUCOSAL ADVANCEMENT					

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
313	40510	EXCISION OF LIP; TRANSVERSE WEDGE EXCISION WITH PRIMARY CLOSURE					
313	40520	EXCISION OF LIP; V-EXCISION WITH PRIMARY DIRECT LINEAR CLOSURE					
313	40525	EXCISION OF LIP; FULL THICKNESS, RECONSTRUCTION WITH LOCAL FLAP (EG, ESTLANDER OR FAN)					
313	40527	EXCISION OF LIP; FULL THICKNESS, RECONSTRUCTION WITH CROSS LIP FLAP (ABBE-ESTLANDER)					
313	40530	RESECTION OF LIP, MORE THAN ONE-FOURTH, WITHOUT RECONSTRUCTION					
313	40650	REPAIR LIP, FULL THICKNESS; VERMILION ONLY					
313	40652	REPAIR LIP, FULL THICKNESS; UP TO HALF VERTICAL HEIGHT					
313	40654	REPAIR LIP, FULL THICKNESS; OVER ONE-HALF VERTICAL HEIGHT, OR COMPLEX					
313	40814	EXCISION OF LESION OF MUCOSA AND SUBMUCOSA, VESTIBULE OF MOUTH; WITH COMPLEX REPAIR					
313	40816	EXCISION OF LESION OF MUCOSA AND SUBMUCOSA, VESTIBULE OF MOUTH; COMPLEX, WITH EXCISION OF UNDERLYING MUSCLE					
313	40818	EXCISION OF MUCOSA OF VESTIBULE OF MOUTH AS DONOR GRAFT					
313	40819	EXCISION OF FRENUM, LABIAL OR BUCCAL (FRENUMECTOMY, FRENULECTOMY, FRENECTOMY)					
313	40840	VESTIBULOPLASTY; ANTERIOR					
313	40842	VESTIBULOPLASTY; POSTERIOR, UNILATERAL					
313	41006	INTRAORAL INCISION AND DRAINAGE OF ABSCESS, CYST, OR HEMATOMA OF TONGUE OR FLOOR OF MOUTH; SUBLINGUAL, DEEP, SUPRAMYLOHYOID					
313	41007	INTRAORAL INCISION AND DRAINAGE OF ABSCESS, CYST, OR HEMATOMA OF TONGUE OR FLOOR OF MOUTH; SUBMENTAL SPACE					
313	41008	INTRAORAL INCISION AND DRAINAGE OF ABSCESS, CYST, OR HEMATOMA OF TONGUE OR FLOOR OF MOUTH; SUBMANDIBULAR					
313	41009	INTRAORAL INCISION AND DRAINAGE OF ABSCESS, CYST, OR HEMATOMA OF TONGUE OR FLOOR OF MOUTH; MASTICATOR SPACE					
313	41010	INCISION OF LINGUAL FRENUM (FRENOTOMY)					
313	41015	EXTRAORAL INCISION AND DRAINAGE OF ABSCESS, CYST, OR HEMATOMA OF FLOOR OF MOUTH; SUBLINGUAL					
313	41016	EXTRAORAL INCISION AND DRAINAGE OF ABSCESS, CYST, OR HEMATOMA OF FLOOR OF MOUTH; SUBMENTAL					
313	41017	EXTRAORAL INCISION AND DRAINAGE OF ABSCESS, CYST, OR HEMATOMA OF FLOOR OF MOUTH; SUBMANDIBULAR					
313	41018	EXTRAORAL INCISION AND DRAINAGE OF ABSCESS, CYST, OR HEMATOMA OF FLOOR OF MOUTH; MASTICATOR SPACE					
313	41112	EXCISION OF LESION OF TONGUE WITH CLOSURE; ANTERIOR TWO-THIRDS					
313	41113	EXCISION OF LESION OF TONGUE WITH CLOSURE; POSTERIOR ONE-THIRD					
313	41114	EXCISION OF LESION OF TONGUE WITH CLOSURE; WITH LOCAL TONGUE FLAP					
313	41116	EXCISION, LESION OF FLOOR OF MOUTH					
313	41120	GLOSSECTOMY; LESS THAN ONE-HALF TONGUE					
313	41520	FRENOPLASTY (SURGICAL REVISION OF FRENUM, EG, WITH Z-PLASTY)					
313	41827	EXCISION OF LESION OR TUMOR (EXCEPT LISTED ABOVE), DENTOALVEOLAR STRUCTURES; WITH COMPLEX REPAIR					
313	42107	EXCISION, LESION OF PALATE, UVULA; WITH LOCAL FLAP CLOSURE					
313	42120	RESECTION OF PALATE OR EXTENSIVE RESECTION OF LESION					
313	42180	REPAIR, LACERATION OF PALATE; UP TO 2 CM					
313	42182	REPAIR, LACERATION OF PALATE; OVER 2 CM OR COMPLEX					
313	42200	PALATOPLASTY FOR CLEFT PALATE, SOFT AND/OR HARD PALATE ONLY					
313	42205	PALATOPLASTY FOR CLEFT PALATE, WITH CLOSURE OF ALVEOLAR RIDGE; SOFT TISSUE ONLY					
313	42215	PALATOPLASTY FOR CLEFT PALATE; MAJOR REVISION					
313	42220	PALATOPLASTY FOR CLEFT PALATE; SECONDARY LENGTHENING PROCEDURE					
313	42235	REPAIR OF ANTERIOR PALATE, INCLUDING VOMER FLAP					
313	42260	REPAIR OF NASOLABIAL FISTULA					
313	42325	FISTULIZATION OF SUBLINGUAL SALIVARY CYST (RANULA);					
313	42326	FISTULIZATION OF SUBLINGUAL SALIVARY CYST (RANULA); WITH PROSTHESIS					
313	42340	SIALOLITHOTOMY; PAROTID, EXTRAORAL OR COMPLICATED INTRAORAL					
313	42408	EXCISION OF SUBLINGUAL SALIVARY CYST (RANULA)					
313	42409	MARSUPIALIZATION OF SUBLINGUAL SALIVARY CYST (RANULA)					
313	42410	EXCISION OF PAROTID TUMOR OR PAROTID GLAND; LATERAL LOBE, WITHOUT NERVE DISSECTION					
313	42440	EXCISION OF SUBMANDIBULAR (SUBMAXILLARY) GLAND					
313	42450	EXCISION OF SUBLINGUAL GLAND					
313	42500	PLASTIC REPAIR OF SALIVARY DUCT, SIALODOCHOPLASTY; PRIMARY OR SIMPLE					
313	42505	PLASTIC REPAIR OF SALIVARY DUCT, SIALODOCHOPLASTY; SECONDARY OR COMPLICATED					
313	42507	PAROTID DUCT DIVERSION, BILATERAL (WILKE TYPE PROCEDURE);					
313	42508	PAROTID DUCT DIVERSION, BILATERAL (WILKE TYPE PROCEDURE); WITH EXCISION OF ONE SUBMANDIBULAR GLAND					
313	42510	PAROTID DUCT DIVERSION, BILATERAL (WILKE TYPE PROCEDURE); WITH LIGATION OF BOTH SUBMANDIBULAR (WHARTON'S) DUCTS					
313	42600	CLOSURE SALIVARY FISTULA					
313	42725	INCISION AND DRAINAGE ABSCESS; RETROPHARYNGEAL OR PARAPHARYNGEAL, EXTERNAL APPROACH					
313	42810	EXCISION BRANCHIAL CLEFT CYST OR VESTIGE, CONFINED TO SKIN AND SUBCUTANEOUS TISSUES					
313	42815	EXCISION BRANCHIAL CLEFT CYST, VESTIGE, OR FISTULA, EXTENDING BENEATH SUBCUTANEOUS TISSUES AND/OR INTO PHARYNX					
313	42900	SUTURE PHARYNX FOR WOUND OR INJURY					
313	42950	PHARYNGOPLASTY (PLASTIC OR RECONSTRUCTIVE OPERATION ON PHARYNX)					
313	42955	PHARYNGOSTOMY (FISTULIZATION OF PHARYNX, EXTERNAL FOR FEEDING)					
313	42962	CONTROL OROPHARYNGEAL HEMORRHAGE, PRIMARY OR SECONDARY (EG, POST-TONSILLECTOMY); WITH SECONDARY SURGICAL INTERVENTION					
313	42972	CONTROL OF NASOPHARYNGEAL HEMORRHAGE, PRIMARY OR SECONDARY (EG, POSTADENOIDECTOMY); WITH SECONDARY SURGICAL INTERVENTION					
313	43020	ESOPHAGOTOMY, CERVICAL APPROACH, WITH REMOVAL OF FOREIGN BODY					
313	43030	CRICOPHARYNGEAL MYOTOMY					
313	69120	EXCISION EXTERNAL EAR; COMPLETE AMPUTATION					
313	69140	EXCISION EXOSTOSIS(ES), EXTERNAL AUDITORY CANAL					
313	69300	OTOPLASTY, PROTRUDING EAR, WITH OR WITHOUT SIZE REDUCTION					
313	69440	MIDDLE EAR EXPLORATION THROUGH POSTAURICULAR OR EAR CANAL INCISION					
313	69450	TYMPANOLYSIS, TRANSCANAL					
313	69620	MYRINGOPLASTY (SURGERY CONFINED TO DRUMHEAD AND DONOR AREA)					
314	Level IV ENT Procedures		T	25.65	$1,299.67	$693.37	$259.93
314	30400	RHINOPLASTY, PRIMARY; LATERAL AND ALAR CARTILAGES AND/OR ELEVATION OF NASAL TIP					

(See Addendum D. for Payment of Medical Visits)

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
314	30410	RHINOPLASTY, PRIMARY; COMPLETE, EXTERNAL PARTS INCLUDING BONY PYRAMID, LATERAL AND ALAR CARTILAGES, AND/OR ELEVATION OF NASAL TIP					
314	30420	RHINOPLASTY, PRIMARY; INCLUDING MAJOR SEPTAL REPAIR					
314	30435	RHINOPLASTY, SECONDARY; INTERMEDIATE REVISION (BONY WORK WITH OSTEOTOMIES)					
314	30450	RHINOPLASTY, SECONDARY; MAJOR REVISION (NASAL TIP WORK AND OSTEOTOMIES)					
314	30460	RHINOPLASTY FOR NASAL DEFORMITY SECONDARY TO CONGENITAL CLEFT LIP AND/OR PALATE, INCLUDING COLUMELLAR LENGTHENING; TIP ONLY					
314	30462	RHINOPLASTY FOR NASAL DEFORMITY SECONDARY TO CONGENITAL CLEFT LIP AND/OR PALATE, INCLUDING COLUMELLAR LENGTHENING; TIP, SEPTUM, OSTEOTOMIES					
314	30545	REPAIR CHOANAL ATRESIA; TRANSPALATINE					
314	31040	PTERYGOMAXILLARY FOSSA SURGERY, ANY APPROACH					
314	31075	SINUSOTOMY FRONTAL; TRANSORBITAL, UNILATERAL (FOR MUCOCELE OR OSTEOMA, LYNCH TYPE)					
314	31080	SINUSOTOMY FRONTAL; OBLITERATIVE WITHOUT OSTEOPLASTIC FLAP, BROW INCISION (INCLUDES ABLATION)					
314	31081	SINUSOTOMY FRONTAL; OBLITERATIVE, WITHOUT OSTEOPLASTIC FLAP, CORONAL INCISION (INCLUDES ABLATION)					
314	31084	SINUSOTOMY FRONTAL; OBLITERATIVE, WITH OSTEOPLASTIC FLAP, BROW INCISION					
314	31085	SINUSOTOMY FRONTAL; OBLITERATIVE, WITH OSTEOPLASTIC FLAP, CORONAL INCISION					
314	31086	SINUSOTOMY FRONTAL; NONOBLITERATIVE, WITH OSTEOPLASTIC FLAP, BROW INCISION					
314	31087	SINUSOTOMY FRONTAL; NONOBLITERATIVE, WITH OSTEOPLASTIC FLAP, CORONAL INCISION					
314	31090	SINUSOTOMY COMBINED, THREE OR MORE SINUSES (UNILATERAL)					
314	31201	ETHMOIDECTOMY; INTRANASAL, TOTAL					
314	31205	ETHMOIDECTOMY; EXTRANASAL, TOTAL					
314	31300	LARYNGOTOMY (THYROTOMY, LARYNGOFISSURE); WITH REMOVAL OF TUMOR OR LARYNGOCELE, CORDECTOMY					
314	31400	ARYTENOIDECTOMY OR ARYTENOIDOPEXY, EXTERNAL APPROACH					
314	31420	EPIGLOTTIDECTOMY					
314	31588	LARYNGOPLASTY, NOT OTHERWISE SPECIFIED (EG, FOR BURNS, RECONSTRUCTION AFTER PARTIAL LARYNGECTOMY)					
314	31590	LARYNGEAL REINNERVATION BY NEUROMUSCULAR PEDICLE					
314	31750	TRACHEOPLASTY; CERVICAL					
314	31755	TRACHEOPLASTY; TRACHEOPHARYNGEAL FISTULIZATION, EACH STAGE					
314	40700	PLASTIC REPAIR OF CLEFT LIP/NASAL DEFORMITY; PRIMARY, PARTIAL OR COMPLETE, UNILATERAL					
314	40701	PLASTIC REPAIR OF CLEFT LIP/NASAL DEFORMITY; PRIMARY BILATERAL, ONE STAGE PROCEDURE					
314	40702	PLASTIC REPAIR OF CLEFT LIP/NASAL DEFORMITY; PRIMARY BILATERAL, ONE OF TWO STAGES					
314	40720	PLASTIC REPAIR OF CLEFT LIP/NASAL DEFORMITY; SECONDARY, BY RECREATION OF DEFECT AND RECLOSURE					
314	40761	PLASTIC REPAIR OF CLEFT LIP/NASAL DEFORMITY; WITH CROSS LIP PEDICLE FLAP (ABBE-ESTLANDER TYPE), INCLUDING SECTIONING AND INSERTING OF PEDICLE					
314	40843	VESTIBULOPLASTY; POSTERIOR, BILATERAL					
314	40844	VESTIBULOPLASTY; ENTIRE ARCH					
314	40845	VESTIBULOPLASTY; COMPLEX (INCLUDING RIDGE EXTENSION, MUSCLE REPOSITIONING)					
314	42210	PALATOPLASTY FOR CLEFT PALATE, WITH CLOSURE OF ALVEOLAR RIDGE; WITH BONE GRAFT TO ALVEOLAR RIDGE (INCLUDES OBTAINING GRAFT)					
314	42225	PALATOPLASTY FOR CLEFT PALATE; ATTACHMENT PHARYNGEAL FLAP					
314	42226	LENGTHENING OF PALATE, AND PHARYNGEAL FLAP					
314	42227	LENGTHENING OF PALATE, WITH ISLAND FLAP					
314	42415	EXCISION OF PAROTID TUMOR OR PAROTID GLAND; LATERAL LOBE, WITH DISSECTION AND PRESERVATION OF FACIAL NERVE					
314	42420	EXCISION OF PAROTID TUMOR OR PAROTID GLAND; TOTAL, WITH DISSECTION AND PRESERVATION OF FACIAL NERVE					
314	42425	EXCISION OF PAROTID TUMOR OR PAROTID GLAND; TOTAL, EN BLOC REMOVAL WITH SACRIFICE OF FACIAL NERVE					
314	42509	PAROTID DUCT DIVERSION, BILATERAL (WILKE TYPE PROCEDURE); WITH EXCISION OF BOTH SUBMANDIBULAR GLANDS					
314	42842	RADICAL RESECTION OF TONSIL, TONSILLAR PILLARS, AND/OR RETROMOLAR TRIGONE; WITHOUT CLOSURE					
314	42844	RADICAL RESECTION OF TONSIL, TONSILLAR PILLARS, AND/OR RETROMOLAR TRIGONE; CLOSURE WITH LOCAL FLAP (EG, TONGUE, BUCCAL)					
314	42890	LIMITED PHARYNGECTOMY					
314	42892	RESECTION OF LATERAL PHARYNGEAL WALL OR PYRIFORM SINUS, DIRECT CLOSURE BY ADVANCEMENT OF LATERAL AND POSTERIOR PHARYNGEAL WALLS					
314	69150	RADICAL EXCISION EXTERNAL AUDITORY CANAL LESION; WITHOUT NECK DISSECTION					
314	69310	RECONSTRUCTION OF EXTERNAL AUDITORY CANAL (MEATOPLASTY) (EG, FOR STENOSIS DUE TO TRAUMA, INFECTION) (SEPARATE PROCEDURE)					
314	69320	RECONSTRUCTION EXTERNAL AUDITORY CANAL FOR CONGENITAL ATRESIA, SINGLE STAGE					
314	69501	TRANSMASTOID ANTROTOMY (''SIMPLE'' MASTOIDECTOMY)					
314	69502	MASTOIDECTOMY; COMPLETE					
314	69505	MASTOIDECTOMY; MODIFIED RADICAL					
314	69511	MASTOIDECTOMY; RADICAL					
314	69530	PETROUS APICECTOMY INCLUDING RADICAL MASTOIDECTOMY					
314	69550	EXCISION AURAL GLOMUS TUMOR; TRANSCANAL					
314	69552	EXCISION AURAL GLOMUS TUMOR; TRANSMASTOID					
314	69601	REVISION MASTOIDECTOMY; RESULTING IN COMPLETE MASTOIDECTOMY					
314	69602	REVISION MASTOIDECTOMY; RESULTING IN MODIFIED RADICAL MASTOIDECTOMY					
314	69603	REVISION MASTOIDECTOMY; RESULTING IN RADICAL MASTOIDECTOMY					
314	69604	REVISION MASTOIDECTOMY; RESULTING IN TYMPANOPLASTY					
314	69605	REVISION MASTOIDECTOMY; WITH APICECTOMY					
314	69631	TYMPANOPLASTY WITHOUT MASTOIDECTOMY (INCLUDING CANALPLASTY, ATTICOTOMY AND/OR MIDDLE EAR SURGERY), INITIAL OR REVISION; WITHOUT OSSICULAR CHAIN RECONSTRUCTION					
314	69632	TYMPANOPLASTY WITHOUT MASTOIDECTOMY (INCLUDING CANALPLASTY, ATTICOTOMY AND/OR MIDDLE EAR SURGERY), INITIAL OR REVISION; WITH OSSICULAR CHAIN RECONSTRUCTION (EG, POSTFENESTRATION)					
314	69633	TYMPANOPLASTY WITHOUT MASTOIDECTOMY (INCLUDING CANALPLASTY, ATTICOTOMY AND/OR MIDDLE EAR SURGERY), INITIAL OR REVISION; WITH OSSICULAR CHAIN RECONSTRUCTION AND SYNTHETIC PROSTHESIS (EG, PARTIAL OSSICULAR REPLACEMENT PROSTHESIS (PORP), TOTAL OSSICULAR REPL					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
314	69635	TYMPANOPLASTY WITH ANTROTOMY OR MASTOIDOTOMY (INCLUDING CANALPLASTY, ATTICOTOMY, MIDDLE EAR SURGERY, AND/OR TYMPANIC MEMBRANE REPAIR); WITHOUT OSSICULAR CHAIN RECONSTRUCTION					
314	69636	TYMPANOPLASTY WITH ANTROTOMY OR MASTOIDOTOMY (INCLUDING CANALPLASTY, ATTICOTOMY, MIDDLE EAR SURGERY, AND/OR TYMPANIC MEMBRANE REPAIR); WITH OSSICULAR CHAIN RECONSTRUCTION					
314	69637	TYMPANOPLASTY WITH ANTROTOMY OR MASTOIDOTOMY (INCLUDING CANALPLASTY, ATTICOTOMY, MIDDLE EAR SURGERY, AND/OR TYMPANIC MEMBRANE REPAIR); WITH OSSICULAR CHAIN RECONSTRUCTION AND SYNTHETIC PROSTHESIS (EG, PARTIAL OSSICULAR REPLACEMENT PROSTHESIS (PORP), TOTAL					
314	69641	TYMPANOPLASTY WITH MASTOIDECTOMY (INCLUDING CANALPLASTY, MIDDLE EAR SURGERY, TYMPANIC MEMBRANE REPAIR); WITHOUT OSSICULAR CHAIN RECONSTRUCTION					
314	69642	TYMPANOPLASTY WITH MASTOIDECTOMY (INCLUDING CANALPLASTY, MIDDLE EAR SURGERY, TYMPANIC MEMBRANE REPAIR); WITH OSSICULAR CHAIN RECONSTRUCTION					
314	69643	TYMPANOPLASTY WITH MASTOIDECTOMY (INCLUDING CANALPLASTY, MIDDLE EAR SURGERY, TYMPANIC MEMBRANE REPAIR); WITH INTACT OR RECONSTRUCTED WALL, WITHOUT OSSICULAR CHAIN RECONSTRUCTION					
314	69644	TYMPANOPLASTY WITH MASTOIDECTOMY (INCLUDING CANALPLASTY, MIDDLE EAR SURGERY, TYMPANIC MEMBRANE REPAIR); WITH INTACT OR RECONSTRUCTED CANAL WALL, WITH OSSICULAR CHAIN RECONSTRUCTION					
314	69645	TYMPANOPLASTY WITH MASTOIDECTOMY (INCLUDING CANALPLASTY, MIDDLE EAR SURGERY, TYMPANIC MEMBRANE REPAIR); RADICAL OR COMPLETE, WITHOUT OSSICULAR CHAIN RECONSTRUCTION					
314	69646	TYMPANOPLASTY WITH MASTOIDECTOMY (INCLUDING CANALPLASTY, MIDDLE EAR SURGERY, TYMPANIC MEMBRANE REPAIR); RADICAL OR COMPLETE, WITH OSSICULAR CHAIN RECONSTRUCTION					
314	69650	STAPES MOBILIZATION					
314	69660	STAPEDECTOMY OR STAPEDOTOMY WITH REESTABLISHMENT OF OSSICULAR CONTINUITY, WITH OR WITHOUT USE OF FOREIGN MATERIAL;					
314	69661	STAPEDECTOMY OR STAPEDOTOMY WITH REESTABLISHMENT OF OSSICULAR CONTINUITY, WITH OR WITHOUT USE OF FOREIGN MATERIAL; WITH FOOTPLATE DRILL OUT					
314	69662	REVISION OF STAPEDECTOMY OR STAPEDOTOMY					
314	69666	REPAIR OVAL WINDOW FISTULA					
314	69667	REPAIR ROUND WINDOW FISTULA					
314	69670	MASTOID OBLITERATION (SEPARATE PROCEDURE)					
314	69676	TYMPANIC NEURECTOMY					
314	69700	CLOSURE POSTAURICULAR FISTULA, MASTOID (SEPARATE PROCEDURE)					
314	69711	REMOVAL OR REPAIR OF ELECTROMAGNETIC BONE CONDUCTION HEARING DEVICE IN TEMPORAL BONE					
314	69720	DECOMPRESSION FACIAL NERVE, INTRATEMPORAL; LATERAL TO GENICULATE GANGLION					
314	69725	DECOMPRESSION FACIAL NERVE, INTRATEMPORAL; INCLUDING MEDIAL TO GENICULATE GANGLION					
314	69740	SUTURE FACIAL NERVE, INTRATEMPORAL, WITH OR WITHOUT GRAFT OR DECOMPRESSION; LATERAL TO GENICULATE GANGLION					
314	69745	SUTURE FACIAL NERVE, INTRATEMPORAL, WITH OR WITHOUT GRAFT OR DECOMPRESSION; INCLUDING MEDIAL TO GENICULATE GANGLION					
314	69801	LABYRINTHOTOMY, WITH OR WITHOUT CRYOSURGERY INCLUDING OTHER NONEXCISIONAL DESTRUCTIVE PROCEDURES OR PERFUSION OF VESTIBULOACTIVE DRUGS (SINGLE OR MULTIPLE PERFUSIONS); TRANSCANAL					
314	69802	LABYRINTHOTOMY, WITH OR WITHOUT CRYOSURGERY INCLUDING OTHER NONEXCISIONAL DESTRUCTIVE PROCEDURES OR PERFUSION OF VESTIBULOACTIVE DRUGS (SINGLE OR MULTIPLE PERFUSIONS); WITH MASTOIDECTOMY					
314	69805	ENDOLYMPHATIC SAC OPERATION; WITHOUT SHUNT					
314	69806	ENDOLYMPHATIC SAC OPERATION; WITH SHUNT					
314	69820	FENESTRATION SEMICIRCULAR CANAL					
314	69840	REVISION FENESTRATION OPERATION					
314	69905	LABYRINTHECTOMY; TRANSCANAL					
314	69910	LABYRINTHECTOMY; WITH MASTOIDECTOMY					
314	69915	VESTIBULAR NERVE SECTION, TRANSLABYRINTHINE APPROACH					
314	69949	UNLISTED PROCEDURE, INNER EAR					
317	Implantation of Cochlear Device		T				
317	69930	COCHLEAR DEVICE IMPLANTATION, WITH OR WITHOUT MASTOIDECTOMY					
318	Nasal Cauterization/Packing		T	2.07	$104.89	$38.65	$20.98
318	30901	CONTROL NASAL HEMORRHAGE, ANTERIOR, SIMPLE (LIMITED CAUTERY AND/OR PACKING) ANY METHOD					
318	30903	CONTROL NASAL HEMORRHAGE, ANTERIOR, COMPLEX (EXTENSIVE CAUTERY AND/OR PACKING) ANY METHOD					
318	30905	CONTROL NASAL HEMORRHAGE, POSTERIOR, WITH POSTERIOR NASAL PACKS AND/OR CAUTERIZATION, ANY METHOD; INITIAL					
318	30906	CONTROL NASAL HEMORRHAGE, POSTERIOR, WITH POSTERIOR NASAL PACKS AND/OR CAUTERIZATION, ANY METHOD;					
318	30999	UNLISTED PROCEDURE, NOSE					
318	42960	CONTROL OROPHARYNGEAL HEMORRHAGE, PRIMARY OR SECONDARY (EG, POST-TONSILLECTOMY); SIMPLE					
318	42970	CONTROL OF NASOPHARYNGEAL HEMORRHAGE, PRIMARY OR SECONDARY (EG, POSTADENOIDECTOMY); SIMPLE, WITH POSTERIOR NASAL PACKS, WITH OR WITHOUT ANTERIOR PACKS AND/OR CAUTERIZATION					
318	42999	UNLISTED PROCEDURE, PHARYNX, ADENOIDS, OR TONSILS					
319	Tonsil/Adenoid Procedures		T	17.30	$876.58	$480.02	$175.32
319	42820	TONSILLECTOMY AND ADENOIDECTOMY; UNDER AGE 12					
319	42821	TONSILLECTOMY AND ADENOIDECTOMY; AGE 12 OR OVER					
319	42825	TONSILLECTOMY, PRIMARY OR SECONDARY; UNDER AGE 12					
319	42826	TONSILLECTOMY, PRIMARY OR SECONDARY; AGE 12 OR OVER					
319	42830	ADENOIDECTOMY, PRIMARY; UNDER AGE 12					
319	42831	ADENOIDECTOMY, PRIMARY; AGE 12 OR OVER					
319	42835	ADENOIDECTOMY, SECONDARY; UNDER AGE 12					
319	42836	ADENOIDECTOMY, SECONDARY; AGE 12 OR OVER					
319	42860	EXCISION OF TONSIL TAGS					
319	42870	EXCISION OR DESTRUCTION LINGUAL TONSIL, ANY METHOD (SEPARATE PROCEDURE)					
320	Thoracentesis/Lavage Procedures		T	3.17	$160.62	$79.33	$32.12
320	32000	THORACENTESIS, PUNCTURE OF PLEURAL CAVITY FOR ASPIRATION, INITIAL OR SUBSEQUENT					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
320	32002	THORACENTESIS WITH INSERTION OF TUBE WITH OR WITHOUT WATER SEAL (EG, FOR PNEUMOTHORAX) (SEPARATE					
320	32020	TUBE THORACOSTOMY WITH OR WITHOUT WATER SEAL (EG, FOR ABSCESS, HEMOTHORAX, EMPYEMA) (SEPARATE PROCEDURE)					
320	32420	PNEUMONOCENTESIS, PUNCTURE OF LUNG FOR ASPIRATION					
320	32960	PNEUMOTHORAX, THERAPEUTIC, INTRAPLEURAL INJECTION OF AIR					
320	32999	UNLISTED PROCEDURE, LUNGS AND PLEURA					
320	33010	PERICARDIOCENTESIS; INITIAL					
320	33011	PERICARDIOCENTESIS; SUBSEQUENT					
320	33999	UNLISTED PROCEDURE, CARDIAC SURGERY					
320	49080	PERITONEOCENTESIS, ABDOMINAL PARACENTESIS, OR PERITONEAL LAVAGE (DIAGNOSTIC OR THERAPEUTIC); INITIAL					
320	49081	PERITONEOCENTESIS, ABDOMINAL PARACENTESIS, OR PERITONEAL LAVAGE (DIAGNOSTIC OR THERAPEUTIC); SUBSEQUENT					
331	Level I Endoscopy Upper Airway		T	0.69	$34.96	$14.01	$6.99
331	31231	NASAL ENDOSCOPY, DIAGNOSTIC, UNILATERAL OR BILATERAL (SEPARATE PROCEDURE)					
331	31299	UNLISTED PROCEDURE, ACCESSORY SINUSES					
331	31505	LARYNGOSCOPY, INDIRECT (SEPARATE PROCEDURE); DIAGNOSTIC					
331	31575	LARYNGOSCOPY, FLEXIBLE FIBEROPTIC; DIAGNOSTIC					
331	31579	LARYNGOSCOPY, FLEXIBLE OR RIGID FIBEROPTIC, WITH STROBOSCOPY					
331	92511	NASOPHARYNGOSCOPY WITH ENDOSCOPE (SEPARATE PROCEDURE)					
332	Level II Endoscopy Upper Airway		T	9.74	$493.52	$244.98	$98.70
332	31233	NASAL/SINUS ENDOSCOPY, DIAGNOSTIC WITH MAXILLARY SINUSOSCOPY (VIA INFERIOR MEATUS OR CANINE FOSSA PUNCTURE)					
332	31235	NASAL/SINUS ENDOSCOPY, DIAGNOSTIC WITH SPHENOID SINUSOSCOPY (VIA PUNCTURE OF SPHENOIDAL FACE OR CANNULATION OF OSTIUM)					
332	31237	NASAL/SINUS ENDOSCOPY, SURGICAL; WITH BIOPSY, POLYPECTOMY OR DEBRIDEMENT (SEPARATE PROCEDURE)					
332	31238	NASAL/SINUS ENDOSCOPY, SURGICAL; WITH CONTROL OF EPISTAXIS					
332	31240	NASAL/SINUS ENDOSCOPY, SURGICAL; WITH CONCHA BULLOSA RESECTION					
332	31510	LARYNGOSCOPY, INDIRECT (SEPARATE PROCEDURE); WITH BIOPSY					
332	31511	LARYNGOSCOPY, INDIRECT (SEPARATE PROCEDURE); WITH REMOVAL OF FOREIGN BODY					
332	31512	LARYNGOSCOPY, INDIRECT (SEPARATE PROCEDURE); WITH REMOVAL OF LESION					
332	31513	LARYNGOSCOPY, INDIRECT (SEPARATE PROCEDURE); WITH VOCAL CORD INJECTION					
332	31515	LARYNGOSCOPY DIRECT, WITH OR WITHOUT TRACHEOSCOPY; FOR ASPIRATION					
332	31520	LARYNGOSCOPY DIRECT, WITH OR WITHOUT TRACHEOSCOPY; DIAGNOSTIC, NEWBORN					
332	31525	LARYNGOSCOPY DIRECT, WITH OR WITHOUT TRACHEOSCOPY; DIAGNOSTIC, EXCEPT NEWBORN					
332	31526	LARYNGOSCOPY DIRECT, WITH OR WITHOUT TRACHEOSCOPY; DIAGNOSTIC, WITH OPERATING MICROSCOPE					
332	31528	LARYNGOSCOPY DIRECT, WITH OR WITHOUT TRACHEOSCOPY; WITH DILATATION, INITIAL					
332	31529	LARYNGOSCOPY DIRECT, WITH OR WITHOUT TRACHEOSCOPY; WITH DILATATION, SUBSEQUENT					
332	31576	LARYNGOSCOPY, FLEXIBLE FIBEROPTIC; WITH BIOPSY					
332	31577	LARYNGOSCOPY, FLEXIBLE FIBEROPTIC; WITH REMOVAL OF FOREIGN BODY					
332	31578	LARYNGOSCOPY, FLEXIBLE FIBEROPTIC; WITH REMOVAL OF LESION					
332	31700	CATHETERIZATION, TRANSGLOTTIC (SEPARATE PROCEDURE)					
332	31717	CATHETERIZATION WITH BRONCHIAL BRUSH BIOPSY					
332	31720	CATHETER ASPIRATION (SEPARATE PROCEDURE); NASOTRACHEAL					
332	31730	TRANSTRACHEAL (PERCUTANEOUS) INTRODUCTION OF NEEDLE WIRE DILATOR/ STENT OR INDWELLING TUBE FOR OXYGEN					
333	Level III Endoscopy Upper Airway		T	17.24	$873.54	$464.20	$174.71
333	31239	NASAL/SINUS ENDOSCOPY, SURGICAL; WITH DACRYOCYSTORHINOSTOMY					
333	31254	NASAL/SINUS ENDOSCOPY, SURGICAL; WITH ETHMOIDECTOMY, PARTIAL (ANTERIOR)					
333	31255	NASAL/SINUS ENDOSCOPY, SURGICAL; WITH ETHMOIDECTOMY, TOTAL (ANTERIOR AND POSTERIOR)					
333	31256	NASAL/SINUS ENDOSCOPY, SURGICAL, WITH MAXILLARY ANTROSTOMY;					
333	31267	NASAL/SINUS ENDOSCOPY, SURGICAL, WITH MAXILLARY ANTROSTOMY; WITH REMOVAL OF TISSUE FROM MAXILLARY SINUS					
333	31276	NASAL/SINUS ENDOSCOPY, SURGICAL WITH FRONTAL SINUS EXPLORATION, WITH OR WITHOUT REMOVAL OF TISSUE FROM FRONTAL SINUS					
333	31287	NASAL/SINUS ENDOSCOPY, SURGICAL, WITH SPHENOIDOTOMY;					
333	31288	NASAL/SINUS ENDOSCOPY, SURGICAL, WITH SPHENOIDOTOMY; WITH REMOVAL OF TISSUE FROM THE SPHENOID SINUS					
333	31527	LARYNGOSCOPY DIRECT, WITH OR WITHOUT TRACHEOSCOPY; WITH INSERTION OF OBTURATOR					
333	31530	LARYNGOSCOPY, DIRECT, OPERATIVE, WITH FOREIGN BODY REMOVAL;					
333	31531	LARYNGOSCOPY, DIRECT, OPERATIVE, WITH FOREIGN BODY REMOVAL; WITH OPERATING MICROSCOPE					
333	31535	LARYNGOSCOPY, DIRECT, OPERATIVE, WITH BIOPSY;					
333	31536	LARYNGOSCOPY, DIRECT, OPERATIVE, WITH BIOPSY; WITH OPERATING MICROSCOPE					
333	31540	LARYNGOSCOPY, DIRECT, OPERATIVE, WITH EXCISION OF TUMOR AND/OR STRIPPING OF VOCAL CORDS OR EPIGLOTTIS;					
333	31541	LARYNGOSCOPY, DIRECT, OPERATIVE, WITH EXCISION OF TUMOR AND/OR STRIPPING OF VOCAL CORDS OR EPIGLOTTIS; WITH OPERATING MICROSCOPE					
333	31560	LARYNGOSCOPY, DIRECT, OPERATIVE, WITH ARYTENOIDECTOMY;					
333	31561	LARYNGOSCOPY, DIRECT, OPERATIVE, WITH ARYTENOIDECTOMY; WITH OPERATING MICROSCOPE					
333	31570	LARYNGOSCOPY, DIRECT, WITH INJECTION INTO VOCAL CORD(S), THERAPEUTIC;					
333	31571	LARYNGOSCOPY, DIRECT, WITH INJECTION INTO VOCAL CORD(S), THERAPEUTIC; WITH OPERATING MICROSCOPE					
336	Endoscopy Lower Airway		T	7.44	$376.98	$197.98	$75.40
336	31615	TRACHEOBRONCHOSCOPY THROUGH ESTABLISHED TRACHEOSTOMY INCISION					
336	31622	BRONCHOSCOPY; DIAGNOSTIC, (FLEXIBLE OR RIGID), WITH OR WITHOUT CELL WASHING OR BRUSHING					
336	31625	BRONCHOSCOPY; WITH BIOPSY					
336	31628	BRONCHOSCOPY; WITH TRANSBRONCHIAL LUNG BIOPSY, WITH OR WITHOUT FLUOROSCOPIC GUIDANCE					
336	31629	BRONCHOSCOPY; WITH TRANSBRONCHIAL NEEDLE ASPIRATION BIOPSY					
336	31630	BRONCHOSCOPY; WITH TRACHEAL OR BRONCHIAL DILATION OR CLOSED REDUCTION OF FRACTURE					
336	31631	BRONCHOSCOPY; WITH TRACHEAL DILATION AND PLACEMENT OF TRACHEAL STENT					
336	31635	BRONCHOSCOPY; WITH REMOVAL OF FOREIGN BODY					
336	31640	BRONCHOSCOPY; WITH EXCISION OF TUMOR					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
336	31641	BRONCHOSCOPY; WITH DESTRUCTION OF TUMOR OR RELIEF OF STENOSIS BY ANY METHOD OTHER THAN EXCISION (EG, LASER)					
336	31645	BRONCHOSCOPY; WITH THERAPEUTIC ASPIRATION OF TRACHEOBRONCHIAL TREE, INITIAL (EG, DRAINAGE OF LUNG ABSCESS)					
336	31646	BRONCHOSCOPY; WITH THERAPEUTIC ASPIRATION OF TRACHEOBRONCHIAL TREE, SUBSEQUENT					
336	31656	BRONCHOSCOPY; WITH INJECTION OF CONTRAST MATERIAL FOR SEGMENTAL BRONCHOGRAPHY (FIBERSCOPE ONLY)					
336	31899	UNLISTED PROCEDURE, TRACHEA, BRONCHI					
339	Injection of Sclerosing Solution		T	1.02	$51.68	$19.66	$10.34
339	36468	SINGLE OR MULTIPLE INJECTIONS OF SCLEROSING SOLUTIONS, SPIDER VEINS (TELANGIECTASIA); LIMB OR TRUNK					
339	36469	SINGLE OR MULTIPLE INJECTIONS OF SCLEROSING SOLUTIONS, SPIDER VEINS (TELANGIECTASIA); FACE					
339	36470	INJECTION OF SCLEROSING SOLUTION; SINGLE VEIN					
339	36471	INJECTION OF SCLEROSING SOLUTION; MULTIPLE VEINS, SAME LEG					
339	45520	PERIRECTAL INJECTION OF SCLEROSING SOLUTION FOR PROLAPSE					
341	Level I Needle and Catheter Placement		T	.13	$6.59	$2.94	$1.32
341	36410	VENIPUNCTURE, CHILD OVER AGE 3 YEARS OR ADULT, NECESSITATING PHYSICIAN'S SKILL (SEPARATE PROCEDURE), FOR DIAGNOSTIC OR THERAPEUTIC PURPOSES. NOT TO BE USED FOR ROUTINE VENIPUNCTURE.					
341	36420	VENIPUNCTURE, CUTDOWN; UNDER AGE 1 YEAR					
341	36425	VENIPUNCTURE, CUTDOWN; AGE 1 OR OVER					
342	Level II Needle and Catheter Placement		T	3.20	$162.14	$80.23	$32.43
342	36010	INTRODUCTION OF CATHETER, SUPERIOR OR INFERIOR VENA CAVA					
342	36011	SELECTIVE CATHETER PLACEMENT, VENOUS SYSTEM; FIRST ORDER BRANCH (EG, RENAL VEIN, JUGULAR VEIN)					
342	36012	SELECTIVE CATHETER PLACEMENT, VENOUS SYSTEM; SECOND ORDER, OR MORE SELECTIVE, BRANCH (EG, LEFT ADRENAL VEIN, PETROSAL SINUS)					
342	36013	INTRODUCTION OF CATHETER, RIGHT HEART OR MAIN PULMONARY ARTERY					
342	36014	SELECTIVE CATHETER PLACEMENT, LEFT OR RIGHT PULMONARY ARTERY					
342	36015	SELECTIVE CATHETER PLACEMENT, SEGMENTAL OR SUBSEGMENTAL PULMONARY ARTERY					
342	36100	INTRODUCTION OF NEEDLE OR INTRACATHETER, CAROTID OR VERTEBRAL ARTERY					
342	36120	INTRODUCTION OF NEEDLE OR INTRACATHETER; RETROGRADE BRACHIAL ARTERY					
342	36140	INTRODUCTION OF NEEDLE OR INTRACATHETER; EXTREMITY ARTERY					
342	36160	INTRODUCTION OF NEEDLE OR INTRACATHETER, AORTIC, TRANSLUMBAR					
342	36200	INTRODUCTION OF CATHETER, AORTA					
342	36500	VENOUS CATHETERIZATION FOR SELECTIVE ORGAN BLOOD SAMPLING					
342	36620	ARTERIAL CATHETERIZATION OR CANNULATION FOR SAMPLING, MONITORING OR TRANSFUSION (SEPARATE PROCEDURE); PERCUTANEOUS					
342	36625	ARTERIAL CATHETERIZATION OR CANNULATION FOR SAMPLING, MONITORING OR TRANSFUSION (SEPARATE PROCEDURE); CUTDOWN					
342	38794	CANNULATION, THORACIC DUCT					
343	Level III Needle and Catheter Placement		T	9.52	$482.37	$224.87	$96.47
343	36215	SELECTIVE CATHETER PLACEMENT, ARTERIAL SYSTEM; EACH FIRST ORDER THORACIC OR BRACHIOCEPHALIC BRANCH, WITHIN A VASCULAR FAMILY					
343	36216	SELECTIVE CATHETER PLACEMENT, ARTERIAL SYSTEM; INITIAL SECOND ORDER THORACIC OR BRACHIOCEPHALIC BRANCH, WITHIN A VASCULAR FAMILY					
343	36217	SELECTIVE CATHETER PLACEMENT, ARTERIAL SYSTEM; INITIAL THIRD ORDER OR MORE SELECTIVE THORACIC OR BRACHIOCEPHALIC BRANCH, WITHIN A VASCULAR FAMILY					
343	36218	SELECTIVE CATHETER PLACEMENT, ARTERIAL SYSTEM; ADDITIONAL SECOND ORDER, THIRD ORDER, AND BEYOND, THORACIC OR BRACHIOCEPHALIC BRANCH, WITHIN A VASCULAR FAMILY (USE IN ADDITION TO 36216 OR 36217 AS APPROPRIATE)					
343	36245	SELECTIVE CATHETER PLACEMENT, ARTERIAL SYSTEM; EACH FIRST ORDER ABDOMINAL, PELVIC, OR LOWER EXTREMITY ARTERY BRANCH, WITHIN A VASCULAR FAMILY					
343	36246	SELECTIVE CATHETER PLACEMENT, ARTERIAL SYSTEM; INITIAL SECOND ORDER ABDOMINAL, PELVIC, OR LOWER EXTREMITY ARTERY BRANCH, WITHIN A VASCULAR FAMILY					
343	36247	SELECTIVE CATHETER PLACEMENT, ARTERIAL SYSTEM; INITIAL THIRD ORDER OR MORE SELECTIVE ABDOMINAL, PELVIC, OR LOWER EXTREMITY ARTERY BRANCH, WITHIN A VASCULAR FAMILY					
343	36248	SELECTIVE CATHETER PLACEMENT, ARTERIAL SYSTEM; ADDITIONAL SECOND ORDER, THIRD ORDER, AND BEYOND, ABDOMINAL, PELVIC, OR LOWER EXTREMITY ARTERY BRANCH, WITHIN A VASCULAR FAMILY (USE IN ADDITION TO 36246 OR 36247 AS APPROPRIATE)					
343	36481	PERCUTANEOUS PORTAL VEIN CATHETERIZATION BY ANY METHOD					
343	93508	CATHETER PLACEMENT IN CORONARY ARTERY(S), ARTERIAL CORONARY CONDUIT(S), AND/OR VENOUS CORONARY BYPASS GRAFT(S) FOR CORONARY ANGIOGRAPHY WITHOUT CONCOMITANT LEFT HEART CATHETERIZATION					
346	Placement Transvenous Caths/Cutdown		T	4.83	$244.73	$120.23	$48.95
346	36488	PLACEMENT OF CENTRAL VENOUS CATHETER (SUBCLAVIAN, JUGULAR, OR OTHER VEIN) (EG, FOR CENTRAL VENOUS PRESSURE, HYPERALIMENTATION, HEMODIALYSIS, OR CHEMOTHERAPY); PERCUTANEOUS, AGE 2 YEARS OR UNDER					
346	36489	PLACEMENT OF CENTRAL VENOUS CATHETER (SUBCLAVIAN, JUGULAR, OR OTHER VEIN) (EG, FOR CENTRAL VENOUS PRESSURE, HYPERALIMENTATION, HEMODIALYSIS, OR CHEMOTHERAPY); PERCUTANEOUS, OVER AGE 2					
346	36490	PLACEMENT OF CENTRAL VENOUS CATHETER (SUBCLAVIAN, JUGULAR, OR OTHER VEIN) (EG, FOR CENTRAL VENOUS PRESSURE, HYPERALIMENTATION, HEMODIALYSIS, OR CHEMOTHERAPY); CUTDOWN, AGE 2 YEARS OR UNDER					
346	36491	PLACEMENT OF CENTRAL VENOUS CATHETER (SUBCLAVIAN, JUGULAR, OR OTHER VEIN) (EG, FOR CENTRAL VENOUS PRESSURE, HYPERALIMENTATION, HEMODIALYSIS, OR CHEMOTHERAPY); CUTDOWN, OVER AGE 2					
346	36493	REPOSITIONING OF PREVIOUSLY PLACED CENTRAL VENOUS CATHETER UNDER FLUOROSCOPIC GUIDANCE					
346	36640	ARTERIAL CATHETERIZATION FOR PROLONGED INFUSION THERAPY (CHEMOTHERAPY), CUTDOWN					
347	Injection Procedures for Interventional Radiology		T	2.93	$148.46	$62.15	$29.69
347	19030	INJECTION PROCEDURE ONLY FOR MAMMARY DUCTOGRAM OR GALACTOGRAM					
347	20501	INJECTION OF SINUS TRACT; DIAGNOSTIC (SINOGRAM)					
347	21116	INJECTION PROCEDURE FOR TEMPOROMANDIBULAR JOINT ARTHROGRAPHY					

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
347	23350	INJECTION PROCEDURE FOR SHOULDER ARTHROGRAPHY					
347	24220	INJECTION PROCEDURE FOR ELBOW ARTHROGRAPHY					
347	25246	INJECTION PROCEDURE FOR WRIST ARTHROGRAPHY					
347	27093	INJECTION PROCEDURE FOR HIP ARTHROGRAPHY; WITHOUT ANESTHESIA					
347	27095	INJECTION PROCEDURE FOR HIP ARTHROGRAPHY; WITH ANESTHESIA					
347	27370	INJECTION PROCEDURE FOR KNEE ARTHROGRAPHY					
347	27648	INJECTION PROCEDURE FOR ANKLE ARTHROGRAPHY					
347	30200	INJECTION INTO TURBINATE(S), THERAPEUTIC					
347	31708	INSTILLATION OF CONTRAST MATERIAL FOR LARYNGOGRAPHY OR BRONCHOGRAPHY, WITHOUT CATHETERIZATION					
347	31710	CATHETERIZATION FOR BRONCHOGRAPHY, WITH OR WITHOUT INSTILLATION OF CONTRAST MATERIAL					
347	31715	TRANSTRACHEAL INJECTION FOR BRONCHOGRAPHY					
347	36005	INJECTION PROCEDURE FOR CONTRAST VENOGRAPHY (INCLUDING INTRODUCTION OF NEEDLE OR INTRACATHETER)					
347	38200	INJECTION PROCEDURE FOR SPLENOPORTOGRAPHY					
347	38790	INJECTION PROCEDURE FOR LYMPHANGIOGRAPHY					
347	42550	INJECTION PROCEDURE FOR SIALOGRAPHY					
347	47500	INJECTION PROCEDURE FOR PERCUTANEOUS TRANSHEPATIC CHOLANGIOGRAPHY					
347	47505	INJECTION PROCEDURE FOR CHOLANGIOGRAPHY THROUGH AN EXISTING CATHETER (EG, PERCUTANEOUS TRANSHEPATIC OR T-TUBE)					
347	49400	INJECTION OF AIR OR CONTRAST INTO PERITONEAL CAVITY (SEPARATE PROCEDURE)					
347	49424	CONTRAST INJECTION FOR ASSESSMENT OF ABSCESS OR CYST VIA PREVIOUSLY PLACED CATHETER (SEPARATE PROCEDURE)					
347	49427	INJECTION PROCEDURE (EG, CONTRAST MEDIA) FOR EVALUATION OF PREVIOUSLY PLACED PERITONEAL-VENOUS SHUNT					
347	50392	INTRODUCTION OF INTRACATHETER OR CATHETER INTO RENAL PELVIS FOR DRAINAGE AND/OR INJECTION, PERCUTANEOUS					
347	50393	INTRODUCTION OF URETERAL CATHETER OR STENT INTO URETER THROUGH RENAL PELVIS FOR DRAINAGE AND/OR INJECTION, PERCUTANEOUS					
347	50394	INJECTION PROCEDURE FOR PYELOGRAPHY (AS NEPHROSTOGRAM, PYELOSTOGRAM, ANTEGRADE PYELOURETEROGRAMS) THROUGH NEPHROSTOMY OR PYELOSTOMY TUBE, OR INDWELLING URETERAL CATHETER					
347	50395	INTRODUCTION OF GUIDE INTO RENAL PELVIS AND/OR URETER WITH DILATION TO ESTABLISH NEPHROSTOMY TRACT, PERCUTANEOUS					
347	50684	INJECTION PROCEDURE FOR URETEROGRAPHY OR URETEROPYELOGRAPHY THROUGH URETEROSTOMY OR INDWELLING URETERAL CATHETER					
347	50690	INJECTION PROCEDURE FOR VISUALIZATION OF ILEAL CONDUIT AND/OR URETEROPYELOGRAPHY, EXCLUSIVE OF RADIOLOGIC SERVICE					
347	51600	INJECTION PROCEDURE FOR CYSTOGRAPHY OR VOIDING URETHROCYSTOGRAPHY					
347	51605	INJECTION PROCEDURE AND PLACEMENT OF CHAIN FOR CONTRAST AND/OR CHAIN URETHROCYSTOGRAPHY					
347	51610	INJECTION PROCEDURE FOR RETROGRADE URETHROCYSTOGRAPHY					
347	54230	INJECTION PROCEDURE FOR CORPORA CAVERNOSOGRAPHY					
347	55300	VASOTOMY FOR VASOGRAMS, SEMINAL VESICULOGRAMS, OR EPIDIDYMOGRAMS, UNILATERAL OR BILATERAL					
347	58340	CATHETERIZATION AND INTRODUCTION OF SALINE OR CONTRAST MATERIAL FOR HYSTEROSONOGRAPHY OR HYSTEROSALPINGOGRAPHY					
347	62284	INJECTION PROCEDURE FOR MYELOGRAPHY AND/OR COMPUTERIZED AXIAL TOMOGRAPHY, SPINAL (OTHER THAN C1-C2 AND POSTERIOR FOSSA)					
347	62290	INJECTION PROCEDURE FOR DISKOGRAPHY, EACH LEVEL; LUMBAR					
347	62291	INJECTION PROCEDURE FOR DISKOGRAPHY, EACH LEVEL; CERVICAL					
347	68850	INJECTION OF CONTRAST MEDIUM FOR DACRYOCYSTOGRAPHY					
360	Removal/Revision, Pacemaker/Vascular Device		T	6.09	$308.58	$140.12	$61.72
360	33222	REVISION OR RELOCATION OF SKIN POCKET FOR PACEMAKER					
360	33223	REVISION OR RELOCATION OF SKIN POCKET FOR IMPLANTABLE CARDIOVERTER-DEFIBRILLATOR					
360	36261	REVISION OF IMPLANTED INTRA-ARTERIAL INFUSION PUMP					
360	36262	REMOVAL OF IMPLANTED INTRA-ARTERIAL INFUSION PUMP					
360	36299	UNLISTED PROCEDURE, VASCULAR INJECTION					
360	36531	REVISION OF IMPLANTABLE INTRAVENOUS INFUSION PUMP					
360	36532	REMOVAL OF IMPLANTABLE INTRAVENOUS INFUSION PUMP					
360	36534	REVISION OF IMPLANTABLE VENOUS ACCESS PORT AND/OR SUBCUTANEOUS RESERVOIR					
419	44377	SMALL INTESTINAL ENDOSCOPY, ENTEROSCOPY BEYOND SECOND PORTION OF DUODENUM, INCLUDING ILEUM; WITH BIOPSY, SINGLE OR MULTIPLE					
419	44378	SMALL INTESTINAL ENDOSCOPY, ENTEROSCOPY BEYOND SECOND PORTION OF DUODENUM, INCLUDING ILEUM; WITH CONTROL OF BLEEDING, ANY METHOD					
419	44799	UNLISTED PROCEDURE, INTESTINE					
426	Diagnostic Lower GI Endoscopy		T	6.85	$347.09	$187.81	$69.42
426	44380	ILEOSCOPY, THROUGH STOMA; DIAGNOSTIC, WITH OR WITHOUT COLLECTION OF SPECIMEN(S) BY BRUSHING OR WASHING (SEPARATE PROCEDURE)					
426	44382	ILEOSCOPY, THROUGH STOMA; WITH BIOPSY, SINGLE OR MULTIPLE					
426	44385	ENDOSCOPIC EVALUATION OF SMALL INTESTINAL (ABDOMINAL OR PELVIC) POUCH; DIAGNOSTIC, WITH OR WITHOUT COLLECTION OF SPECIMEN(S) BY BRUSHING OR WASHING (SEPARATE PROCEDURE)					
426	44386	ENDOSCOPIC EVALUATION OF SMALL INTESTINAL (ABDOMINAL OR PELVIC) POUCH; WITH BIOPSY, SINGLE OR MULTIPLE					
426	44388	COLONOSCOPY THROUGH STOMA; DIAGNOSTIC, WITH OR WITHOUT COLLECTION OF SPECIMEN(S) BY BRUSHING OR WASHING (SEPARATE PROCEDURE)					
426	44389	COLONOSCOPY THROUGH STOMA; WITH BIOPSY, SINGLE OR MULTIPLE					
426	45378	COLONOSCOPY, FLEXIBLE, PROXIMAL TO SPLENIC FLEXURE; DIAGNOSTIC, WITH OR WITHOUT COLLECTION OF SPECIMEN(S) BY BRUSHING OR WASHING, WITH OR WITHOUT COLON DECOMPRESSION (SEPARATE PROCEDURE)					
426	45380	COLONOSCOPY, FLEXIBLE, PROXIMAL TO SPLENIC FLEXURE; WITH BIOPSY, SINGLE OR MULTIPLE					
426	G0105	Colorectal Ca screening, pt at high risk					
427	Therapeutic Lower GI Endoscopy		T	8.22	$416.5	$224.19	$83.3
427	44390	COLONOSCOPY THROUGH STOMA; WITH REMOVAL OF FOREIGN BODY					

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
427	44391	COLONOSCOPY THROUGH STOMA; WITH CONTROL OF BLEEDING, ANY METHOD					
427	44392	COLONOSCOPY THROUGH STOMA; WITH REMOVAL OF TUMOR(S), POLYP(S), OR OTHER LESION(S) BY HOT BIOPSY FORCEPS OR BIPOLAR CAUTERY					
427	44394	COLONOSCOPY THROUGH STOMA; WITH REMOVAL OF TUMOR(S), POLYP(S), OR OTHER LESION(S) BY SNARE TECHNIQUE					
427	45355	COLONOSCOPY, RIGID OR FLEXIBLE, TRANSABDOMINAL VIA COLOTOMY, SINGLE OR MULTIPLE					
427	45379	COLONOSCOPY, FLEXIBLE, PROXIMAL TO SPLENIC FLEXURE; WITH REMOVAL OF FOREIGN BODY					
427	45382	COLONOSCOPY, FLEXIBLE, PROXIMAL TO SPLENIC FLEXURE; WITH CONTROL OF BLEEDING, ANY METHOD					
427	45384	COLONOSCOPY, FLEXIBLE, PROXIMAL TO SPLENIC FLEXURE; WITH REMOVAL OF TUMOR(S), POLYP(S), OR OTHER LESION(S) BY HOT BIOPSY FORCEPS OR BIPOLAR CAUTERY					
427	45385	COLONOSCOPY, FLEXIBLE, PROXIMAL TO SPLENIC FLEXURE; WITH REMOVAL OF TUMOR(S), POLYP(S), OR OTHER LESION(S) BY SNARE TECHNIQUE					
437	Therapeutic Anoscopy		T	2.91	$147.45	$76.61	$29.49
437	46608	ANOSCOPY; WITH REMOVAL OF FOREIGN BODY					
437	46610	ANOSCOPY; WITH REMOVAL OF SINGLE TUMOR, POLYP, OR OTHER LESION BY HOT BIOPSY FORCEPS OR BIPOLAR CAUTERY					
437	46611	ANOSCOPY; WITH REMOVAL OF SINGLE TUMOR, POLYP, OR OTHER LESION BY SNARE TECHNIQUE					
437	46612	ANOSCOPY; WITH REMOVAL OF MULTIPLE TUMORS, POLYPS, OR OTHER LESIONS BY HOT BIOPSY FORCEPS, BIPOLAR CAUTERY OR SNARE TECHNIQUE					
437	46614	ANOSCOPY; WITH CONTROL OF BLEEDING, ANY METHOD					
437	46615	ANOSCOPY; WITH ABLATION OF TUMOR(S), POLYP(S), OR OTHER LESION(S) NOT AMENABLE TO REMOVAL BY HOT BIOPSY FORCEPS, BIPOLAR CAUTERY OR SNARE TECHNIQUE					
446	Diagnostic Sigmoidoscopy		T	2.59	$131.23	$65.09	$26.25
446	45300	PROCTOSIGMOIDOSCOPY, RIGID; DIAGNOSTIC, WITH OR WITHOUT COLLECTION OF SPECIMEN(S) BY BRUSHING OR WASHING (SEPARATE PROCEDURE)					
446	45305	PROCTOSIGMOIDOSCOPY, RIGID; WITH BIOPSY, SINGLE OR MULTIPLE					
446	45330	SIGMOIDOSCOPY, FLEXIBLE; DIAGNOSTIC, WITH OR WITHOUT COLLECTION OF SPECIMEN(S) BY BRUSHING OR WASHING (SEPARATE PROCEDURE)					
446	45331	SIGMOIDOSCOPY, FLEXIBLE; WITH BIOPSY, SINGLE OR MULTIPLE					
446	G0104	Colorectal Ca screening					
447	Therapeutic Proctosigmoidoscopy		T	6.87	$348.10	$184.76	$69.62
447	45303	PROCTOSIGMOIDOSCOPY, RIGID; WITH DILATION, ANY METHOD					
447	45307	PROCTOSIGMOIDOSCOPY, RIGID; WITH REMOVAL OF FOREIGN BODY					
447	45308	PROCTOSIGMOIDOSCOPY, RIGID; WITH REMOVAL OF SINGLE TUMOR, POLYP, OR OTHER LESION BY HOT BIOPSY FORCEPS OR BIPOLAR CAUTERY					
447	45309	PROCTOSIGMOIDOSCOPY, RIGID; WITH REMOVAL OF SINGLE TUMOR, POLYP, OR OTHER LESION BY SNARE TECHNIQUE					
447	45315	PROCTOSIGMOIDOSCOPY, RIGID; WITH REMOVAL OF MULTIPLE TUMORS, POLYPS, OR OTHER LESIONS BY HOT BIOPSY FORCEPS, BIPOLAR CAUTERY OR SNARE TECHNIQUE					
447	45317	PROCTOSIGMOIDOSCOPY, RIGID; WITH CONTROL OF BLEEDING, ANY METHOD					
447	45320	PROCTOSIGMOIDOSCOPY, RIGID; WITH ABLATION OF TUMOR(S), POLYP(S), OR OTHER LESION(S) NOT AMENABLE TO REMOVAL BY HOT BIOPSY FORCEPS, BIPOLAR CAUTERY OR SNARE TECHNIQUE (EG, LASER)					
447	45321	PROCTOSIGMOIDOSCOPY, RIGID; WITH DECOMPRESSION OF VOLVULUS					
448	Therapeutic Flexible Sigmoidoscopy		T	5.37	$272.09	$141.25	$54.42
448	45332	SIGMOIDOSCOPY, FLEXIBLE; WITH REMOVAL OF FOREIGN BODY					
448	45333	SIGMOIDOSCOPY, FLEXIBLE; WITH REMOVAL OF TUMOR(S), POLYP(S), OR OTHER LESION(S) BY HOT BIOPSY FORCEPS OR BIPOLAR CAUTERY					
448	45334	SIGMOIDOSCOPY, FLEXIBLE; WITH CONTROL OF BLEEDING, ANY METHOD					
448	45337	SIGMOIDOSCOPY, FLEXIBLE; WITH DECOMPRESSION OF VOLVULUS, ANY METHOD					
448	45338	SIGMOIDOSCOPY, FLEXIBLE; WITH REMOVAL OF TUMOR(S), POLYP(S), OR OTHER LESION(S) BY SNARE TECHNIQUE					
449	Complex GI Endoscopy		T	7.8	$395.22	$215.38	$79.04
449	43219	ESOPHAGOSCOPY, RIGID OR FLEXIBLE; WITH INSERTION OF PLASTIC TUBE OR STENT					
449	43228	ESOPHAGOSCOPY, RIGID OR FLEXIBLE; WITH ABLATION OF TUMOR(S), POLYP(S), OR OTHER LESION(S), NOT AMENABLE TO REMOVAL BY HOT BIOPSY FORCEPS, BIPOLAR CAUTERY OR SNARE TECHNIQUE					
449	43258	UPPER GASTROINTESTINAL ENDOSCOPY INCLUDING ESOPHAGUS, STOMACH, AND EITHER THE DUODENUM AND/OR JEJUNUM AS APPROPRIATE; WITH ABLATION OF TUMOR(S), POLYP(S), OR OTHER LESION(S) NOT AMENABLE TO REMOVAL BY HOT BIOPSY FORCEPS, BIPOLAR CAUTERY OR SNARE TECHNIQUE					
449	43259	UPPER GASTROINTESTINAL ENDOSCOPY INCLUDING ESOPHAGUS, STOMACH, AND EITHER THE DUODENUM AND/OR JEJUNUM AS APPROPRIATE; WITH ENDOSCOPIC ULTRASOUND EXAMINATION					
449	43272	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (ERCP); WITH ABLATION OF TUMOR(S), POLYP(S), OR OTHER LESION(S) NOT AMENABLE TO REMOVAL BY HOT BIOPSY FORCEPS, BIPOLAR CAUTERY OR SNARE TECHNIQUE					
449	44369	SMALL INTESTINAL ENDOSCOPY, ENTEROSCOPY BEYOND SECOND PORTION OF DUODENUM, NOT INCLUDING ILEUM; WITH ABLATION OF TUMOR(S), POLYP(S), OR OTHER LESION(S) NOT AMENABLE TO REMOVAL BY HOT BIOPSY FORCEPS, BIPOLAR CAUTERY OR SNARE TECHNIQUE					
449	44393	COLONOSCOPY THROUGH STOMA; WITH ABLATION OF TUMOR(S), POLYP(S), OR OTHER LESION(S) NOT AMENABLE TO REMOVAL BY HOT BIOPSY FORCEPS, BIPOLAR CAUTERY OR SNARE TECHNIQUE					
449	45339	SIGMOIDOSCOPY, FLEXIBLE; WITH ABLATION OF TUMOR(S), POLYP(S), OR OTHER LESION(S) NOT AMENABLE TO REMOVAL BY HOT BIOPSY FORCEPS, BIPOLAR CAUTERY OR SNARE TECHNIQUE					
449	45383	COLONOSCOPY, FLEXIBLE, PROXIMAL TO SPLENIC FLEXURE; WITH ABLATION OF TUMOR(S), POLYP(S), OR OTHER LESION(S) NOT AMENABLE TO REMOVAL BY HOT BIOPSY FORCEPS, BIPOLAR CAUTERY OR SNARE TECHNIQUE					
451	Level I Anal/Rectal Procedures		T	2.56	$129.71	$54.24	$25.94
451	46070	INCISION, ANAL SEPTUM (INFANT)					
451	46083	INCISION OF THROMBOSED HEMORRHOID, EXTERNAL					
451	46220	PAPILLECTOMY OR EXCISION OF SINGLE TAG, ANUS (SEPARATE PROCEDURE)					

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
451	46221	HEMORRHOIDECTOMY, BY SIMPLE LIGATURE (EG, RUBBER BAND)					
451	46230	EXCISION OF EXTERNAL HEMORRHOID TAGS AND/OR MULTIPLE PAPILLAE					
451	46320	ENUCLEATION OR EXCISION OF EXTERNAL THROMBOTIC HEMORRHOID					
451	46500	INJECTION OF SCLEROSING SOLUTION, HEMORRHOIDS					
451	46934	DESTRUCTION OF HEMORRHOIDS, ANY METHOD; INTERNAL					
451	46935	DESTRUCTION OF HEMORRHOIDS, ANY METHOD; EXTERNAL					
451	46936	DESTRUCTION OF HEMORRHOIDS, ANY METHOD; INTERNAL AND EXTERNAL					
451	46940	CURETTAGE OR CAUTERIZATION OF ANAL FISSURE, INCLUDING DILATION OF ANAL SPHINCTER (SEPARATE PROCEDURE); INITIAL					
451	46942	CURETTAGE OR CAUTERIZATION OF ANAL FISSURE, INCLUDING DILATION OF ANAL SPHINCTER (SEPARATE PROCEDURE); SUBSEQUENT					
451	46945	LIGATION OF INTERNAL HEMORRHOIDS; SINGLE PROCEDURE					
451	46946	LIGATION OF INTERNAL HEMORRHOIDS; MULTIPLE PROCEDURES					
452	Level II Anal/Rectal Procedures		T	4.82	$244.23	$109.61	$48.85
452	45000	TRANSRECTAL DRAINAGE OF PELVIC ABSCESS					
452	45005	INCISION AND DRAINAGE OF SUBMUCOSAL ABSCESS, RECTUM					
452	45020	INCISION AND DRAINAGE OF DEEP SUPRALEVATOR, PELVIRECTAL, OR RETRORECTAL ABSCESS					
452	45100	BIOPSY OF ANORECTAL WALL, ANAL APPROACH (EG, CONGENITAL MEGACOLON)					
452	45900	REDUCTION OF PROCIDENTIA (SEPARATE PROCEDURE) UNDER ANESTHESIA					
452	45905	DILATION OF ANAL SPHINCTER (SEPARATE PROCEDURE) UNDER ANESTHESIA OTHER THAN LOCAL					
452	45910	DILATION OF RECTAL STRICTURE (SEPARATE PROCEDURE) UNDER ANESTHESIA OTHER THAN LOCAL					
452	45915	REMOVAL OF FECAL IMPACTION OR FOREIGN BODY (SEPARATE PROCEDURE) UNDER ANESTHESIA					
452	45999	UNLISTED PROCEDURE, RECTUM					
452	46030	REMOVAL OF ANAL SETON, OTHER MARKER					
452	46040	INCISION AND DRAINAGE OF ISCHIORECTAL AND/OR PERIRECTAL ABSCESS (SEPARATE PROCEDURE)					
452	46050	INCISION AND DRAINAGE, PERIANAL ABSCESS, SUPERFICIAL					
452	46080	SPHINCTEROTOMY, ANAL, DIVISION OF SPHINCTER (SEPARATE PROCEDURE)					
452	46210	CRYPTECTOMY; SINGLE					
452	46754	REMOVAL OF THIERSCH WIRE OR SUTURE, ANAL CANAL					
452	46999	UNLISTED PROCEDURE, ANUS					
453	Level III Anal/Rectal Procedures		T	16.87	$854.79	$445.22	$170.96
453	45108	ANORECTAL MYOMECTOMY					
453	45150	DIVISION OF STRICTURE OF RECTUM					
453	45160	EXCISION OF RECTAL TUMOR BY PROCTOTOMY, TRANSSACRAL OR TRANSCOCCYGEAL APPROACH					
453	45170	EXCISION OF RECTAL TUMOR, TRANSANAL APPROACH					
453	45190	DESTRUCTION OF RECTAL TUMOR, ANY METHOD (EG, ELECTRODESICCATION) TRANSANAL APPROACH					
453	45500	PROCTOPLASTY; FOR STENOSIS					
453	45505	PROCTOPLASTY; FOR PROLAPSE OF MUCOUS MEMBRANE					
453	45560	REPAIR OF RECTOCELE (SEPARATE PROCEDURE)					
453	46045	INCISION AND DRAINAGE OF INTRAMURAL, INTRAMUSCULAR, OR SUBMUCOSAL ABSCESS, TRANSANAL, UNDER ANESTHESIA					
453	46060	INCISION AND DRAINAGE OF ISCHIORECTAL OR INTRAMURAL ABSCESS, WITH FISTULECTOMY OR FISTULOTOMY, SUBMUSCULAR, WITH OR WITHOUT PLACEMENT OF SETON					
453	46200	FISSURECTOMY, WITH OR WITHOUT SPHINCTEROTOMY					
453	46211	CRYPTECTOMY; MULTIPLE (SEPARATE PROCEDURE)					
453	46250	HEMORRHOIDECTOMY, EXTERNAL, COMPLETE					
453	46255	HEMORRHOIDECTOMY, INTERNAL AND EXTERNAL, SIMPLE;					
453	46257	HEMORRHOIDECTOMY, INTERNAL AND EXTERNAL, SIMPLE; WITH FISSURECTOMY					
453	46258	HEMORRHOIDECTOMY, INTERNAL AND EXTERNAL, SIMPLE; WITH FISTULECTOMY, WITH OR WITHOUT FISSURECTOMY					
453	46260	HEMORRHOIDECTOMY, INTERNAL AND EXTERNAL, COMPLEX OR EXTENSIVE;					
453	46261	HEMORRHOIDECTOMY, INTERNAL AND EXTERNAL, COMPLEX OR EXTENSIVE; WITH FISSURECTOMY					
453	46262	HEMORRHOIDECTOMY, INTERNAL AND EXTERNAL, COMPLEX OR EXTENSIVE; WITH FISTULECTOMY, WITH OR WITHOUT FISSURECTOMY					
453	46270	SURGICAL TREATMENT OF ANAL FISTULA (FISTULECTOMY/FISTULOTOMY); SUBCUTANEOUS					
453	46275	SURGICAL TREATMENT OF ANAL FISTULA (FISTULECTOMY/FISTULOTOMY); SUBMUSCULAR					
453	46280	SURGICAL TREATMENT OF ANAL FISTULA (FISTULECTOMY/FISTULOTOMY); COMPLEX OR MULTIPLE, WITH OR WITHOUT PLACEMENT OF SETON					
453	46285	SURGICAL TREATMENT OF ANAL FISTULA (FISTULECTOMY/FISTULOTOMY); SECOND STAGE					
453	46288	CLOSURE OF ANAL FISTULA WITH RECTAL ADVANCEMENT FLAP					
453	46700	ANOPLASTY, PLASTIC OPERATION FOR STRICTURE; ADULT					
453	46750	SPHINCTEROPLASTY, ANAL, FOR INCONTINENCE OR PROLAPSE; ADULT					
453	46753	GRAFT (THIERSCH OPERATION) FOR RECTAL INCONTINENCE AND/OR PROLAPSE					
453	46760	SPHINCTEROPLASTY, ANAL, FOR INCONTINENCE, ADULT; MUSCLE TRANSPLANT					
453	46761	SPHINCTEROPLASTY, ANAL, FOR INCONTINENCE, ADULT; LEVATOR MUSCLE IMBRICATION (PARK POSTERIOR ANAL REPAIR)					
453	46762	SPHINCTEROPLASTY, ANAL, FOR INCONTINENCE, ADULT; IMPLANTATION ARTIFICIAL SPHINCTER					
453	46937	CRYOSURGERY OF RECTAL TUMOR; BENIGN					
453	46938	CRYOSURGERY OF RECTAL TUMOR; MALIGNANT					
456	Endoscopic Retrograde Cholangiopancreatography (ERCP)		T	9.78	$495.55	$257.19	$99.11
456	43260	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (ERCP); DIAGNOSTIC, WITH OR WITHOUT COLLECTION OF SPECIMEN(S) BY BRUSHING OR WASHING (SEPARATE PROCEDURE)					
456	43261	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (ERCP); WITH BIOPSY, SINGLE OR MULTIPLE					
456	43262	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (ERCP); WITH SPHINCTEROTOMY/PAPILLOTOMY					
456	43263	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (ERCP); WITH PRESSURE MEASUREMENT OF SPHINCTER OF ODDI (PANCREATIC DUCT OR COMMON BILE DUCT)					
456	43264	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (ERCP); WITH ENDOSCOPIC RETROGRADE REMOVAL OF STONE(S) FROM BILIARY AND/OR PANCREATIC DUCTS					

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
456	43265	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (ERCP); WITH ENDOSCOPIC RETROGRADE DESTRUCTION, LITHOTRIPSY OF STONE(S), ANY METHOD					
456	43267	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (ERCP); WITH ENDOSCOPIC RETROGRADE INSERTION OF NASOBILIARY OR NASOPANCREATIC DRAINAGE TUBE					
456	43268	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (ERCP); WITH ENDOSCOPIC RETROGRADE INSERTION OF TUBE OR STENT INTO BILE OR PANCREATIC DUCT					
456	43269	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (ERCP); WITH ENDOSCOPIC RETROGRADE REMOVAL OF FOREIGN BODY AND/OR CHANGE OF TUBE OR STENT					
456	43271	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (ERCP); WITH ENDOSCOPIC RETROGRADE BALLOON DILATION OF AMPULLA, BILIARY AND/OR PANCREATIC DUCT(S)					
458	Percutaneous Biliary Endoscopic Procedures		T	7.23	$366.34	$181.59	$73.27
458	47510	INTRODUCTION OF PERCUTANEOUS TRANSHEPATIC CATHETER FOR BILIARY DRAINAGE					
458	47511	INTRODUCTION OF PERCUTANEOUS TRANSHEPATIC STENT FOR INTERNAL AND EXTERNAL BILIARY DRAINAGE					
458	47552	BILIARY ENDOSCOPY, PERCUTANEOUS VIA T-TUBE OR OTHER TRACT; DIAGNOSTIC, WITH OR WITHOUT COLLECTION OF SPECIMEN(S) BY BRUSHING AND/OR WASHING (SEPARATE PROCEDURE)					
458	47553	BILIARY ENDOSCOPY, PERCUTANEOUS VIA T-TUBE OR OTHER TRACT; WITH BIOPSY, SINGLE OR MULTIPLE					
458	47554	BILIARY ENDOSCOPY, PERCUTANEOUS VIA T-TUBE OR OTHER TRACT; WITH REMOVAL OF STONE(S)					
458	47555	BILIARY ENDOSCOPY, PERCUTANEOUS VIA T-TUBE OR OTHER TRACT; WITH DILATION OF BILIARY DUCT STRICTURE(S) WITHOUT STENT					
458	47556	BILIARY ENDOSCOPY, PERCUTANEOUS VIA T-TUBE OR OTHER TRACT; WITH DILATION OF BILIARY DUCT STRICTURE(S) WITH STENT					
458	47630	BILIARY DUCT STONE EXTRACTION, PERCUTANEOUS VIA T-TUBE TRACT, BASKET, OR SNARE (EG, BURHENNE TECHNIQUE)					
459	Peritoneal and Abdominal Procedures		T	18.06	$915.09	$496.52	$183.02
459	49085	REMOVAL OF PERITONEAL FOREIGN BODY FROM PERITONEAL CAVITY					
459	49250	UMBILECTOMY, OMPHALECTOMY, EXCISION OF UMBILICUS (SEPARATE PROCEDURE)					
459	49420	INSERTION OF INTRAPERITONEAL CANNULA OR CATHETER FOR DRAINAGE OR DIALYSIS; TEMPORARY					
459	49421	INSERTION OF INTRAPERITONEAL CANNULA OR CATHETER FOR DRAINAGE OR DIALYSIS; PERMANENT					
459	49423	EXCHANGE OF PREVIOUSLY PLACED ABSCESS OR CYST DRAINAGE CATHETER UNDER RADIOLOGICAL GUIDANCE (SEPARATE PROCEDURE)					
459	49426	REVISION OF PERITONEAL-VENOUS SHUNT					
466	Hernia/Hydrocele Procedures		T	21.43	$1,085.85	$562.97	$217.17
466	49495	REPAIR INITIAL INGUINAL HERNIA, UNDER AGE 6 MONTHS, WITH OR WITHOUT HYDROCELECTOMY; REDUCIBLE					
466	49496	REPAIR INITIAL INGUINAL HERNIA, UNDER AGE 6 MONTHS, WITH OR WITHOUT HYDROCELECTOMY; INCARCERATED OR STRANGULATED					
466	49500	REPAIR INITIAL INGUINAL HERNIA, AGE 6 MONTHS TO UNDER 5 YEARS, WITH OR WITHOUT HYDROCELECTOMY; REDUCIBLE					
466	49501	REPAIR INITIAL INGUINAL HERNIA, AGE 6 MONTHS TO UNDER 5 YEARS, WITH OR WITHOUT HYDROCELECTOMY; INCARCERATED OR STRANGULATED					
466	49505	REPAIR INITIAL INGUINAL HERNIA, AGE 5 YEARS OR OVER; REDUCIBLE					
466	49507	REPAIR INITIAL INGUINAL HERNIA, AGE 5 YEARS OR OVER; INCARCERATED OR STRANGULATED					
466	49520	REPAIR RECURRENT INGUINAL HERNIA, ANY AGE; REDUCIBLE					
466	49521	REPAIR RECURRENT INGUINAL HERNIA, ANY AGE; INCARCERATED OR STRANGULATED					
466	49525	REPAIR INGUINAL HERNIA, SLIDING, ANY AGE					
466	49540	REPAIR LUMBAR HERNIA					
466	49550	REPAIR INITIAL FEMORAL HERNIA, ANY AGE, REDUCIBLE;					
466	49553	REPAIR INITIAL FEMORAL HERNIA, ANY AGE, REDUCIBLE; INCARCERATED OR STRANGULATED					
466	49555	REPAIR RECURRENT FEMORAL HERNIA; REDUCIBLE					
466	49557	REPAIR RECURRENT FEMORAL HERNIA; INCARCERATED OR STRANGULATED					
466	49560	REPAIR INITIAL INCISIONAL OR VENTRAL HERNIA; REDUCIBLE					
466	49561	REPAIR INITIAL INCISIONAL OR VENTRAL HERNIA; INCARCERATED OR STRANGULATED					
466	49565	REPAIR RECURRENT INCISIONAL OR VENTRAL HERNIA; REDUCIBLE					
466	49566	REPAIR RECURRENT INCISIONAL OR VENTRAL HERNIA; INCARCERATED OR STRANGULATED					
466	49568	IMPLANTATION OF MESH OR OTHER PROSTHESIS FOR INCISIONAL OR VENTRAL HERNIA REPAIR (LIST SEPARATELY IN ADDITION TO CODE FOR THE INCISIONAL OR VENTRAL HERNIA REPAIR)					
466	49570	REPAIR EPIGASTRIC HERNIA (EG, PREPERITONEAL FAT); REDUCIBLE (SEPARATE PROCEDURE)					
466	49572	REPAIR EPIGASTRIC HERNIA (EG, PREPERITONEAL FAT); INCARCERATED OR STRANGULATED					
466	49580	REPAIR UMBILICAL HERNIA, UNDER AGE 5 YEARS; REDUCIBLE					
466	49582	REPAIR UMBILICAL HERNIA, UNDER AGE 5 YEARS; INCARCERATED OR STRANGULATED					
466	49585	REPAIR UMBILICAL HERNIA, AGE 5 YEARS OR OVER; REDUCIBLE					
466	49587	REPAIR UMBILICAL HERNIA, AGE 5 YEARS OR OVER; INCARCERATED OR STRANGULATED					
466	49590	REPAIR SPIGELIAN HERNIA					
466	49600	REPAIR OF SMALL OMPHALOCELE, WITH PRIMARY CLOSURE					
466	51500	EXCISION OF URACHAL CYST OR SINUS, WITH OR WITHOUT UMBILICAL HERNIA REPAIR					
466	55040	EXCISION OF HYDROCELE; UNILATERAL					
466	55041	EXCISION OF HYDROCELE; BILATERAL					
470	Tube Procedures		T	2.22	$112.49	$54.92	$22.50
470	31502	TRACHEOTOMY TUBE CHANGE PRIOR TO ESTABLISHMENT OF FISTULA TRACT					
470	43760	CHANGE OF GASTROSTOMY TUBE					
470	43761	REPOSITIONING OF THE GASTRIC FEEDING TUBE THROUGH THE DUODENUM FOR ENTERIC NUTRITION					
470	43999	UNLISTED PROCEDURE, STOMACH					
470	47525	CHANGE OF PERCUTANEOUS BILIARY DRAINAGE CATHETER					
470	47530	REVISION AND/OR REINSERTION OF TRANSHEPATIC TUBE					
470	47999	UNLISTED PROCEDURE, BILIARY TRACT					
470	49422	REMOVAL OF PERMANENT INTRAPERITONEAL CANNULA OR CATHETER					
470	49429	REMOVAL OF PERITONEAL-VENOUS SHUNT					

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
470	49999	UNLISTED PROCEDURE, ABDOMEN, PERITONEUM AND OMENTUM					
470	50688	CHANGE OF URETEROSTOMY TUBE					
470	51705	CHANGE OF CYSTOSTOMY TUBE; SIMPLE					
470	51710	CHANGE OF CYSTOSTOMY TUBE; COMPLICATED					
521	Level I Cystourethroscopy and other Genitourinary Procedures		T	5.06	$256.39	$112.10	$51.28
521	50398	CHANGE OF NEPHROSTOMY OR PYELOSTOMY TUBE					
521	52000	CYSTOURETHROSCOPY (SEPARATE PROCEDURE)					
521	52265	CYSTOURETHROSCOPY, WITH DILATION OF BLADDER FOR INTERSTITIAL CYSTITIS; LOCAL ANESTHESIA					
522	Level II Cystourethroscopy and other Genitourinary Procedures		T	10.46	$530.00	$262.39	$106.00
522	50551	RENAL ENDOSCOPY THROUGH ESTABLISHED NEPHROSTOMY OR PYELOSTOMY, WITH OR WITHOUT IRRIGATION, INSTILLATION, OR URETEROPYELOGRAPHY, EXCLUSIVE OF RADIOLOGIC SERVICE;					
522	50553	RENAL ENDOSCOPY THROUGH ESTABLISHED NEPHROSTOMY OR PYELOSTOMY, WITH OR WITHOUT IRRIGATION, INSTILLATION, OR URETEROPYELOGRAPHY, EXCLUSIVE OF RADIOLOGIC SERVICE; WITH URETERAL CATHETERIZATION, WITH OR WITHOUT DILATION OF URETER					
522	50555	RENAL ENDOSCOPY THROUGH ESTABLISHED NEPHROSTOMY OR PYELOSTOMY, WITH OR WITHOUT IRRIGATION, INSTILLATION, OR URETEROPYELOGRAPHY, EXCLUSIVE OF RADIOLOGIC SERVICE; WITH BIOPSY					
522	50557	RENAL ENDOSCOPY THROUGH ESTABLISHED NEPHROSTOMY OR PYELOSTOMY, WITH OR WITHOUT IRRIGATION, INSTILLATION, OR URETEROPYELOGRAPHY, EXCLUSIVE OF RADIOLOGIC SERVICE; WITH FULGURATION AND/OR INCISION, WITH OR WITHOUT BIOPSY					
522	50559	RENAL ENDOSCOPY THROUGH ESTABLISHED NEPHROSTOMY OR PYELOSTOMY, WITH OR WITHOUT IRRIGATION, INSTILLATION, OR URETEROPYELOGRAPHY, EXCLUSIVE OF RADIOLOGIC SERVICE; WITH INSERTION OF RADIOACTIVE SUBSTANCE WITH OR WITHOUT BIOPSY AND/OR FULGURATION					
522	50561	RENAL ENDOSCOPY THROUGH ESTABLISHED NEPHROSTOMY OR PYELOSTOMY, WITH OR WITHOUT IRRIGATION, INSTILLATION, OR URETEROPYELOGRAPHY, EXCLUSIVE OF RADIOLOGIC SERVICE; WITH REMOVAL OF FOREIGN BODY OR CALCULUS					
522	52005	CYSTOURETHROSCOPY, WITH URETERAL CATHETERIZATION, WITH OR WITHOUT IRRIGATION, INSTILLATION, OR URETEROPYELOGRAPHY, EXCLUSIVE OF RADIOLOGIC SERVICE;					
522	52007	CYSTOURETHROSCOPY, WITH URETERAL CATHETERIZATION, WITH OR WITHOUT IRRIGATION, INSTILLATION, OR URETEROPYELOGRAPHY, EXCLUSIVE OF RADIOLOGIC SERVICE; WITH BRUSH BIOPSY OF URETER AND/OR RENAL PELVIS					
522	52010	CYSTOURETHROSCOPY, WITH EJACULATORY DUCT CATHETERIZATION, WITH OR WITHOUT IRRIGATION, INSTILLATION, OR DUCT RADIOGRAPHY, EXCLUSIVE OF RADIOLOGIC SERVICE					
522	52204	CYSTOURETHROSCOPY, WITH BIOPSY					
522	52214	CYSTOURETHROSCOPY, WITH FULGURATION (INCLUDING CRYOSURGERY OR LASER SURGERY) OF TRIGONE, BLADDER NECK, PROSTATIC FOSSA, URETHRA, OR PERIURETHRAL GLANDS					
522	52224	CYSTOURETHROSCOPY, WITH FULGURATION (INCLUDING CRYOSURGERY OR LASER SURGERY) OR TREATMENT OF MINOR (LESS THAN 0.5 CM) LESION(S) WITH OR WITHOUT BIOPSY					
522	52260	CYSTOURETHROSCOPY, WITH DILATION OF BLADDER FOR INTERSTITIAL CYSTITIS; GENERAL OR CONDUCTION (SPINAL) ANESTHESIA					
522	52270	CYSTOURETHROSCOPY, WITH INTERNAL URETHROTOMY; FEMALE					
522	52275	CYSTOURETHROSCOPY, WITH INTERNAL URETHROTOMY; MALE					
522	52276	CYSTOURETHROSCOPY WITH DIRECT VISION INTERNAL URETHROTOMY					
522	52281	CYSTOURETHROSCOPY, WITH CALIBRATION AND/OR DILATION OF URETHRAL STRICTURE OR STENOSIS, WITH OR WITHOUT MEATOTOMY, WITH OR WITHOUT INJECTION PROCEDURE FOR CYSTOGRAPHY, MALE OR FEMALE					
522	52283	CYSTOURETHROSCOPY, WITH STEROID INJECTION INTO STRICTURE					
522	52285	CYSTOURETHROSCOPY FOR TREATMENT OF THE FEMALE URETHRAL SYNDROME WITH ANY OR ALL OF THE FOLLOWING: URETHRAL MEATOTOMY, URETHRAL DILATION, INTERNAL URETHROTOMY, LYSIS OF URETHROVAGINAL SEPTAL FIBROSIS, LATERAL INCISIONS OF THE BLADDER NECK, AND FULGURATION					
522	52290	CYSTOURETHROSCOPY; WITH URETERAL MEATOTOMY, UNILATERAL OR BILATERAL					
522	52300	CYSTOURETHROSCOPY; WITH RESECTION OR FULGURATION OF ORTHOTOPIC URETEROCELE(S), UNILATERAL OR BILATERAL					
522	52301	CYSTOURETHROSCOPY; WITH RESECTION OR FULGURATION OF ECTOPIC URETEROCELE(S), UNILATERAL OR BILATERAL					
522	52305	CYSTOURETHROSCOPY; WITH INCISION OR RESECTION OF ORIFICE OF BLADDER DIVERTICULUM, SINGLE OR MULTIPLE					
522	52310	CYSTOURETHROSCOPY, WITH REMOVAL OF FOREIGN BODY, CALCULUS, OR URETERAL STENT FROM URETHRA OR BLADDER (SEPARATE PROCEDURE); SIMPLE					
522	52315	CYSTOURETHROSCOPY, WITH REMOVAL OF FOREIGN BODY, CALCULUS, OR URETERAL STENT FROM URETHRA OR BLADDER (SEPARATE PROCEDURE); COMPLICATED					
522	52327	CYSTOURETHROSCOPY (INCLUDING URETERAL CATHETERIZATION); WITH SUBURETERIC INJECTION OF IMPLANT MATERIAL					
522	52510	TRANSURETHRAL BALLOON DILATION OF THE PROSTATIC URETHRA, ANY METHOD					
522	53605	DILATION OF URETHRAL STRICTURE OR VESICAL NECK BY PASSAGE OF SOUND OR URETHRAL DILATOR, MALE, GENERAL OR CONDUCTION (SPINAL) ANESTHESIA					
523	Level III Cystourethroscopy and other Genitourinary Procedures		T	16.87	$854.79	$447.03	$170.96
523	50951	URETERAL ENDOSCOPY THROUGH ESTABLISHED URETEROSTOMY, WITH OR WITHOUT IRRIGATION, INSTILLATION, OR URETEROPYELOGRAPHY, EXCLUSIVE OF RADIOLOGIC SERVICE;					
523	50953	URETERAL ENDOSCOPY THROUGH ESTABLISHED URETEROSTOMY, WITH OR WITHOUT IRRIGATION, INSTILLATION, OR URETEROPYELOGRAPHY, EXCLUSIVE OF RADIOLOGIC SERVICE; WITH URETERAL CATHETERIZATION, WITH OR WITHOUT DILATION OF URETER					
523	50955	URETERAL ENDOSCOPY THROUGH ESTABLISHED URETEROSTOMY, WITH OR WITHOUT IRRIGATION, INSTILLATION, OR URETEROPYELOGRAPHY, EXCLUSIVE OF RADIOLOGIC SERVICE; WITH BIOPSY					
523	50957	URETERAL ENDOSCOPY THROUGH ESTABLISHED URETEROSTOMY, WITH OR WITHOUT IRRIGATION, INSTILLATION, OR URETEROPYELOGRAPHY, EXCLUSIVE OF RADIOLOGIC SERVICE; WITH FULGURATION AND/OR INCISION, WITH OR WITHOUT BIOPSY					
523	50959	URETERAL ENDOSCOPY THROUGH ESTABLISHED URETEROSTOMY, WITH OR WITHOUT IRRIGATION, INSTILLATION, OR URETEROPYELOGRAPHY, EXCLUSIVE OF RADIOLOGIC SERVICE; WITH INSERTION OF RADIOACTIVE SUBSTANCE, WITH OR WITHOUT BIOPSY AND/OR FULGURATION (NOT INCLUDING PROVIS)					
523	50961	URETERAL ENDOSCOPY THROUGH ESTABLISHED URETEROSTOMY, WITH OR WITHOUT IRRIGATION, INSTILLATION, OR URETEROPYELOGRAPHY, EXCLUSIVE OF RADIOLOGIC SERVICE; WITH REMOVAL OF FOREIGN BODY OR CALCULUS					
523	51020	CYSTOTOMY OR CYSTOSTOMY; WITH FULGURATION AND/OR INSERTION OF RADIOACTIVE MATERIAL					
523	51030	CYSTOTOMY OR CYSTOSTOMY; WITH CRYOSURGICAL DESTRUCTION OF INTRAVESICAL LESION					

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
523	51040	CYSTOSTOMY, CYSTOTOMY WITH DRAINAGE					
523	51045	CYSTOTOMY, WITH INSERTION OF URETERAL CATHETER OR STENT (SEPARATE PROCEDURE)					
523	51050	CYSTOLITHOTOMY, CYSTOTOMY WITH REMOVAL OF CALCULUS, WITHOUT VESICAL NECK RESECTION					
523	51065	CYSTOTOMY, WITH STONE BASKET EXTRACTION AND/OR ULTRASONIC OR ELECTROHYDRAULIC FRAGMENTATION OF URETERAL CALCULUS					
523	51520	CYSTOTOMY; FOR SIMPLE EXCISION OF VESICAL NECK (SEPARATE PROCEDURE)					
523	51880	CLOSURE OF CYSTOSTOMY (SEPARATE PROCEDURE)					
523	52234	CYSTOURETHROSCOPY, WITH FULGURATION (INCLUDING CRYOSURGERY OR LASER SURGERY) AND/OR RESECTION OF; SMALL BLADDER TUMOR(S) (0.5 TO 2.0 CM)					
523	52235	CYSTOURETHROSCOPY, WITH FULGURATION (INCLUDING CRYOSURGERY OR LASER SURGERY) AND/OR RESECTION OF; MEDIUM BLADDER TUMOR(S) (2.0 TO 5.0 CM)					
523	52240	CYSTOURETHROSCOPY, WITH FULGURATION (INCLUDING CRYOSURGERY OR LASER SURGERY) AND/OR RESECTION OF; LARGE BLADDER TUMOR(S)					
523	52250	CYSTOURETHROSCOPY WITH INSERTION OF RADIOACTIVE SUBSTANCE, WITH OR WITHOUT BIOPSY OR FULGURATION					
523	52277	CYSTOURETHROSCOPY, WITH RESECTION OF EXTERNAL SPHINCTER (SPHINCTEROTOMY)					
523	52282	CYSTOURETHROSCOPY, WITH INSERTION OF URETHRAL STENT					
523	52317	LITHOLAPAXY: CRUSHING OR FRAGMENTATION OF CALCULUS BY ANY MEANS IN BLADDER AND REMOVAL OF FRAGMENTS; SIMPLE OR SMALL (LESS THAN 2.5 CM)					
523	52318	LITHOLAPAXY: CRUSHING OR FRAGMENTATION OF CALCULUS BY ANY MEANS IN BLADDER AND REMOVAL OF FRAGMENTS; COMPLICATED OR LARGE (OVER 2.5 CM)					
523	52320	CYSTOURETHROSCOPY (INCLUDING URETERAL CATHETERIZATION); WITH REMOVAL OF URETERAL CALCULUS					
523	52325	CYSTOURETHROSCOPY (INCLUDING URETERAL CATHETERIZATION); WITH FRAGMENTATION OF URETERAL CALCULUS (EG, ULTRASONIC OR ELECTRO-HYDRAULIC TECHNIQUE)					
523	52330	CYSTOURETHROSCOPY (INCLUDING URETERAL CATHETERIZATION); WITH MANIPULATION, WITHOUT REMOVAL OF URETERAL CALCULUS					
523	52332	CYSTOURETHROSCOPY, WITH INSERTION OF INDWELLING URETERAL STENT (EG, GIBBONS OR DOUBLE-J TYPE)					
523	52334	CYSTOURETHROSCOPY WITH INSERTION OF URETERAL GUIDE WIRE THROUGH KIDNEY TO ESTABLISH A PERCUTANEOUS NEPHROSTOMY, RETROGRADE					
523	52335	CYSTOURETHROSCOPY, WITH URETEROSCOPY AND/OR PYELOSCOPY (INCLUDES DILATION OF THE URETER AND/OR PYELOURETERAL JUNCTION BY ANY METHOD);					
523	52336	CYSTOURETHROSCOPY, WITH URETEROSCOPY AND/OR PYELOSCOPY (INCLUDES DILATION OF THE URETER AND/OR PYELOURETERAL JUNCTION BY ANY METHOD); WITH REMOVAL OR MANIPULATION OF CALCULUS (URETERAL CATHETERIZATION IS INCLUDED)					
523	52338	CYSTOURETHROSCOPY, WITH URETEROSCOPY AND/OR PYELOSCOPY (INCLUDES DILATION OF THE URETER AND/OR PYELOURETERAL JUNCTION BY ANY METHOD); WITH BIOPSY AND/OR FULGURATION OF LESION					
523	52339	CYSTOURETHROSCOPY, WITH URETEROSCOPY AND/OR PYELOSCOPY (INCLUDES DILATION OF THE URETER AND/OR PYELOURETERAL JUNCTION BY ANY METHOD); WITH RESECTION OF TUMOR					
523	52340	CYSTOURETHROSCOPY WITH INCISION, FULGURATION, OR RESECTION OF CONGENITAL POSTERIOR URETHRAL VALVES, OR CONGENITAL OBSTRUCTIVE HYPERTROPHIC MUCOSAL FOLDS					
523	52450	TRANSURETHRAL INCISION OF PROSTATE					
523	52500	TRANSURETHRAL RESECTION OF BLADDER NECK (SEPARATE PROCEDURE)					
523	52606	TRANSURETHRAL FULGURATION FOR POSTOPERATIVE BLEEDING OCCURRING AFTER THE USUAL FOLLOW-UP TIME					
523	52640	TRANSURETHRAL RESECTION; OF POSTOPERATIVE BLADDER NECK CONTRACTURE					
523	52700	TRANSURETHRAL DRAINAGE OF PROSTATIC ABSCESS					
523	55720	PROSTATOTOMY, EXTERNAL DRAINAGE OF PROSTATIC ABSCESS, ANY APPROACH; SIMPLE					
523	55725	PROSTATOTOMY, EXTERNAL DRAINAGE OF PROSTATIC ABSCESS, ANY APPROACH; COMPLICATED					
523	55859	TRANSPERINEAL PLACEMENT OF NEEDLES OR CATHETERS INTO PROSTATE FOR INTERSTITIAL RADIOELEMENT APPLICATION, WITH OR WITHOUT CYSTOSCOPY					
524	Level IV Cystourethroscopy and other Genitourinary Procedures		T	28.89	$1,463.84	$833.38	$292.77
524	52337	CYSTOURETHROSCOPY, WITH URETEROSCOPY AND/OR PYELOSCOPY (INCLUDES DILATION OF THE URETER AND/OR PYELOURETERAL JUNCTION BY ANY METHOD); WITH LITHOTRIPSY (URETERAL CATHETERIZATION IS INCLUDED)					
524	52601	TRANSURETHRAL ELECTROSURGICAL RESECTION OF PROSTATE, INCLUDING CONTROL OF POSTOPERATIVE BLEEDING, COMPLETE (VASECTOMY, MEATOTOMY, CYSTOURETHROSCOPY, URETHRAL CALIBRATION AND/OR DILATION, AND INTERNAL URETHROTOMY ARE INCLUDED)					
524	52612	TRANSURETHRAL RESECTION OF PROSTATE; FIRST STAGE OF TWO-STAGE RESECTION (PARTIAL RESECTION)					
524	52614	TRANSURETHRAL RESECTION OF PROSTATE; SECOND STAGE OF TWO-STAGE RESECTION (RESECTION COMPLETED)					
524	52620	TRANSURETHRAL RESECTION; OF RESIDUAL OBSTRUCTIVE TISSUE AFTER 90 DAYS POSTOPERATIVE					
524	52630	TRANSURETHRAL RESECTION; OF REGROWTH OF OBSTRUCTIVE TISSUE LONGER THAN ONE YEAR POSTOPERATIVE					
524	52647	NON-CONTACT LASER COAGULATION OF PROSTATE, INCLUDING CONTROL OF POSTOPERATIVE BLEEDING, COMPLETE (VASECTOMY, MEATOTOMY, CYSTOURETHROSCOPY, URETHRAL CALIBRATION AND/OR DILATION, AND INTERNAL URETHROTOMY ARE INCLUDED)					
524	52648	CONTACT LASER VAPORIZATION WITH OR WITHOUT TRANSURETHRAL RESECTION OF PROSTATE, INCLUDING CONTROL OF POSTOPERATIVE BLEEDING, COMPLETE (VASECTOMY, MEATOTOMY, CYSTOURETHROSCOPY, URETHRAL CALIBRATION AND/OR DILATION, AND INTERNAL URETHROTOMY ARE INCLUDED)					
524	53850	TRANSURETHRAL DESTRUCTION OF PROSTATE TISSUE; BY MICROWAVE THERMOTHERAPY					
524	53852	TRANSURETHRAL DESTRUCTION OF PROSTATE TISSUE; BY RADIOFREQUENCY THERMOTHERAPY					
527	Lithotripsy		T	51.56	$2,612.52	$1,372.95	$522.5
527	50590	LITHOTRIPSY, EXTRACORPOREAL SHOCK WAVE					
529	Simple Urinary Studies and Procedures		T	2.5	$126.67	$63.05	$25.33
529	50396	MANOMETRIC STUDIES THROUGH NEPHROSTOMY OR PYELOSTOMY TUBE, OR INDWELLING URETERAL CATHETER					
529	50686	MANOMETRIC STUDIES THROUGH URETEROSTOMY OR INDWELLING URETERAL CATHETER					
529	51725	SIMPLE CYSTOMETROGRAM (CMG) (EG, SPINAL MANOMETER)					
529	51726	COMPLEX CYSTOMETROGRAM (EG, CALIBRATED ELECTRONIC EQUIPMENT)					
529	51736	SIMPLE UROFLOWMETRY (UFR) (EG, STOP-WATCH FLOW RATE, MECHANICAL UROFLOWMETER)					

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
529	51741	COMPLEX UROFLOWMETRY (EG, CALIBRATED ELECTRONIC EQUIPMENT)					
529	51772	URETHRAL PRESSURE PROFILE STUDIES (UPP) (URETHRAL CLOSURE PRESSURE PROFILE), ANY TECHNIQUE					
529	51784	ELECTROMYOGRAPHY STUDIES (EMG) OF ANAL OR URETHRAL SPHINCTER, OTHER THAN NEEDLE, ANY TECHNIQUE					
529	51785	NEEDLE ELECTROMYOGRAPHY STUDIES (EMG) OF ANAL OR URETHRAL SPHINCTER, ANY TECHNIQUE					
529	51792	STIMULUS EVOKED RESPONSE (EG, MEASUREMENT OF BULBOCAVERNOSUS REFLEX LATENCY TIME)					
529	51795	VOIDING PRESSURE STUDIES (VP); BLADDER VOIDING PRESSURE, ANY TECHNIQUE					
529	51797	VOIDING PRESSURE STUDIES (VP); INTRA-ABDOMINAL VOIDING PRESSURE (AP) (RECTAL, GASTRIC, INTRAPERITONEAL)					
529	54240	PENILE PLETHYSMOGRAPHY					
529	54250	NOCTURNAL PENILE TUMESCENCE AND/OR RIGIDITY TEST					
530	Genitourinary Procedures		T	2.52	$127.69	$54.69	$25.54
530	51000	ASPIRATION OF BLADDER BY NEEDLE					
530	51005	ASPIRATION OF BLADDER; BY TROCAR OR INTRACATHETER					
530	51010	ASPIRATION OF BLADDER; WITH INSERTION OF SUPRAPUBIC CATHETER					
530	51700	BLADDER IRRIGATION, SIMPLE, LAVAGE AND/OR INSTILLATION					
530	51720	BLADDER INSTILLATION OF ANTICARCINOGENIC AGENT (INCLUDING DETENTION TIME)					
530	53600	DILATION OF URETHRAL STRICTURE BY PASSAGE OF SOUND OR URETHRAL DILATOR, MALE; INITIAL					
530	53601	DILATION OF URETHRAL STRICTURE BY PASSAGE OF SOUND OR URETHRAL DILATOR, MALE; SUBSEQUENT					
530	53620	DILATION OF URETHRAL STRICTURE BY PASSAGE OF FILIFORM AND FOLLOWER, MALE; INITIAL					
530	53621	DILATION OF URETHRAL STRICTURE BY PASSAGE OF FILIFORM AND FOLLOWER, MALE; SUBSEQUENT					
530	53660	DILATION OF FEMALE URETHRA INCLUDING SUPPOSITORY AND/OR INSTILLATION; INITIAL					
530	53661	DILATION OF FEMALE URETHRA INCLUDING SUPPOSITORY AND/OR INSTILLATION; SUBSEQUENT					
530	53675	CATHETERIZATION, URETHRA; COMPLICATED (MAY INCLUDE DIFFICULT REMOVAL OF BALLOON CATHETER)					
530	53899	UNLISTED PROCEDURE, URINARY SYSTEM					
530	54200	INJECTION PROCEDURE FOR PEYRONIE DISEASE;					
530	54220	IRRIGATION OF CORPORA CAVERNOSA FOR PRIAPISM					
530	54231	DYNAMIC CAVERNOSOMETRY, INCLUDING INTRACAVERNOSAL INJECTION OF VASOACTIVE DRUGS (EG, PAPAVERINE, PHENTOLAMINE)					
530	54235	INJECTION OF CORPORA CAVERNOSA WITH PHARMACOLOGIC AGENT(S) (EG, PAPAVERINE, PHENTOLAMINE)					
530	54450	FORESKIN MANIPULATION INCLUDING LYSIS OF PREPUTIAL ADHESIONS AND STRETCHING					
530	55899	UNLISTED PROCEDURE, MALE GENITAL SYSTEM					
531	Level I Urethral Procedures		T	18.94	$959.68	$527.26	$191.94
531	51715	ENDOSCOPIC INJECTION OF IMPLANT MATERIAL INTO THE SUBMUCOSAL TISSUES OF THE URETHRA AND/OR BLADDER NECK					
531	53000	URETHROTOMY OR URETHROSTOMY, EXTERNAL (SEPARATE PROCEDURE); PENDULOUS URETHRA					
531	53010	URETHROTOMY OR URETHROSTOMY, EXTERNAL (SEPARATE PROCEDURE); PERINEAL URETHRA, EXTERNAL					
531	53020	MEATOTOMY, CUTTING OF MEATUS (SEPARATE PROCEDURE); EXCEPT INFANT					
531	53025	MEATOTOMY, CUTTING OF MEATUS (SEPARATE PROCEDURE); INFANT					
531	53040	DRAINAGE OF DEEP PERIURETHRAL ABSCESS					
531	53060	DRAINAGE OF SKENE'S GLAND ABSCESS OR CYST					
531	53080	DRAINAGE OF PERINEAL URINARY EXTRAVASATION; UNCOMPLICATED (SEPARATE PROCEDURE)					
531	53200	BIOPSY OF URETHRA					
531	53250	EXCISION OF BULBOURETHRAL GLAND (COWPER'S GLAND)					
531	53260	EXCISION OR FULGURATION; URETHRAL POLYP(S), DISTAL URETHRA					
531	53265	EXCISION OR FULGURATION; URETHRAL CARUNCLE					
531	53270	EXCISION OR FULGURATION; SKENE'S GLANDS					
531	53275	EXCISION OR FULGURATION; URETHRAL PROLAPSE					
531	53442	REMOVAL OF PERINEAL PROSTHESIS INTRODUCED FOR CONTINENCE					
531	53502	URETHRORRHAPHY, SUTURE OF URETHRAL WOUND OR INJURY, FEMALE					
531	53505	URETHRORRHAPHY, SUTURE OF URETHRAL WOUND OR INJURY; PENILE					
531	53510	URETHRORRHAPHY, SUTURE OF URETHRAL WOUND OR INJURY; PERINEAL					
531	53665	DILATION OF FEMALE URETHRA, GENERAL OR CONDUCTION (SPINAL) ANESTHESIA					
531	54000	SLITTING OF PREPUCE, DORSAL OR LATERAL (SEPARATE PROCEDURE); NEWBORN					
531	54001	SLITTING OF PREPUCE, DORSAL OR LATERAL (SEPARATE PROCEDURE); EXCEPT NEWBORN					
532	Level II Urethral Procedures		T	25.5	$1,292.07	$602.18	$258.41
532	53210	URETHRECTOMY, TOTAL, INCLUDING CYSTOSTOMY; FEMALE					
532	53215	URETHRECTOMY, TOTAL, INCLUDING CYSTOSTOMY; MALE					
532	53220	EXCISION OR FULGURATION OF CARCINOMA OF URETHRA					
532	53230	EXCISION OF URETHRAL DIVERTICULUM (SEPARATE PROCEDURE); FEMALE					
532	53235	EXCISION OF URETHRAL DIVERTICULUM (SEPARATE PROCEDURE); MALE					
532	53240	MARSUPIALIZATION OF URETHRAL DIVERTICULUM, MALE OR FEMALE					
532	53400	URETHROPLASTY; FIRST STAGE, FOR FISTULA, DIVERTICULUM, OR STRICTURE (EG, JOHANNSEN TYPE)					
532	53405	URETHROPLASTY; SECOND STAGE (FORMATION OF URETHRA), INCLUDING URINARY DIVERSION					
532	53410	URETHROPLASTY, ONE-STAGE RECONSTRUCTION OF MALE ANTERIOR URETHRA					
532	53420	URETHROPLASTY, TWO-STAGE RECONSTRUCTION OR REPAIR OF PROSTATIC OR MEMBRANOUS URETHRA; FIRST STAGE					
532	53425	URETHROPLASTY, TWO-STAGE RECONSTRUCTION OR REPAIR OF PROSTATIC OR MEMBRANOUS URETHRA; SECOND STAGE					
532	53430	URETHROPLASTY, RECONSTRUCTION OF FEMALE URETHRA					
532	53447	REMOVAL, REPAIR, OR REPLACEMENT OF INFLATABLE SPHINCTER INCLUDING PUMP AND/OR RESERVOIR AND/OR CUFF					
532	53449	SURGICAL CORRECTION OF HYDRAULIC ABNORMALITY OF INFLATABLE SPHINCTER DEVICE					
532	53450	URETHROMEATOPLASTY, WITH MUCOSAL ADVANCEMENT					
532	53460	URETHROMEATOPLASTY, WITH PARTIAL EXCISION OF DISTAL URETHRAL SEGMENT (RICHARDSON TYPE PROCEDURE)					
532	53515	URETHRORRHAPHY, SUTURE OF URETHRAL WOUND OR INJURY; PROSTATOMEMBRANOUS					
532	53520	CLOSURE OF URETHROSTOMY OR URETHROCUTANEOUS FISTULA, MALE (SEPARATE PROCEDURE)					
536	Circumcision		T	13.17	$667.32	$326.57	$133.46
536	54150	CIRCUMCISION, USING CLAMP OR OTHER DEVICE; NEWBORN					

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
536	54152	CIRCUMCISION, USING CLAMP OR OTHER DEVICE; EXCEPT NEWBORN					
536	54160	CIRCUMCISION, SURGICAL EXCISION OTHER THAN CLAMP, DEVICE OR DORSAL SLIT; NEWBORN					
536	54161	CIRCUMCISION, SURGICAL EXCISION OTHER THAN CLAMP, DEVICE OR DORSAL SLIT; EXCEPT NEWBORN					
537	Penile Procedures		T	28.72	$1,455.23	$864.34	$291.05
537	37790	PENILE VENOUS OCCLUSIVE PROCEDURE					
537	54110	EXCISION OF PENILE PLAQUE (PEYRONIE DISEASE);					
537	54111	EXCISION OF PENILE PLAQUE (PEYRONIE DISEASE); WITH GRAFT TO 5 CM IN LENGTH					
537	54112	EXCISION OF PENILE PLAQUE (PEYRONIE DISEASE); WITH GRAFT GREATER THAN 5 CM IN LENGTH					
537	54120	AMPUTATION OF PENIS; PARTIAL					
537	54205	INJECTION PROCEDURE FOR PEYRONIE DISEASE; WITH SURGICAL EXPOSURE OF PLAQUE					
537	54300	PLASTIC OPERATION OF PENIS FOR STRAIGHTENING OF CHORDEE (EG, HYPOSPADIAS), WITH OR WITHOUT MOBILIZATION OF URETHRA					
537	54304	PLASTIC OPERATION ON PENIS FOR CORRECTION OF CHORDEE OR FOR FIRST STAGE HYPOSPADIAS REPAIR WITH OR WITHOUT TRANSPLANTATION OF PREPUCE AND/OR SKIN FLAPS					
537	54308	URETHROPLASTY FOR SECOND STAGE HYPOSPADIAS REPAIR (INCLUDING URINARY DIVERSION); LESS THAN 3 CM					
537	54312	URETHROPLASTY FOR SECOND STAGE HYPOSPADIAS REPAIR (INCLUDING URINARY DIVERSION); GREATER THAN 3 CM					
537	54316	URETHROPLASTY FOR SECOND STAGE HYPOSPADIAS REPAIR (INCLUDING URINARY DIVERSION) WITH FREE SKIN GRAFT OBTAINED FROM SITE OTHER THAN GENITALIA					
537	54318	URETHROPLASTY FOR THIRD STAGE HYPOSPADIAS REPAIR TO RELEASE PENIS FROM SCROTUM (EG, THIRD STAGE CECIL					
537	54322	ONE STAGE DISTAL HYPOSPADIAS REPAIR (WITH OR WITHOUT CHORDEE OR CIRCUMCISION); WITH SIMPLE MEATAL ADVANCEMENT (EG, MAGPI, V-FLAP)					
537	54324	ONE STAGE DISTAL HYPOSPADIAS REPAIR (WITH OR WITHOUT CHORDEE OR CIRCUMCISION); WITH URETHROPLASTY BY LOCAL SKIN FLAPS (EG, FLIP-FLAP, PREPUCIAL FLAP)					
537	54326	ONE STAGE DISTAL HYPOSPADIAS REPAIR (WITH OR WITHOUT CHORDEE OR CIRCUMCISION); WITH URETHROPLASTY BY LOCAL SKIN FLAPS AND MOBILIZATION OF URETHRA					
537	54328	ONE STAGE DISTAL HYPOSPADIAS REPAIR (WITH OR WITHOUT CHORDEE OR CIRCUMCISION); WITH EXTENSIVE DISSECTION TO CORRECT CHORDEE AND URETHROPLASTY WITH LOCAL SKIN FLAPS, SKIN GRAFT PATCH, AND/OR ISLAND FLAP					
537	54340	REPAIR OF HYPOSPADIAS COMPLICATIONS (IE, FISTULA, STRICTURE, DIVERTICULA); BY CLOSURE, INCISION, OR EXCISION,					
537	54344	REPAIR OF HYPOSPADIAS COMPLICATIONS (IE, FISTULA, STRICTURE, DIVERTICULA); REQUIRING MOBILIZATION OF SKIN FLAPS AND URETHROPLASTY WITH FLAP OR PATCH GRAFT					
537	54348	REPAIR OF HYPOSPADIAS COMPLICATIONS (IE, FISTULA, STRICTURE, DIVERTICULA); REQUIRING EXTENSIVE DISSECTION AND URETHROPLASTY WITH FLAP, PATCH OR TUBED GRAFT (INCLUDES URINARY DIVERSION)					
537	54352	REPAIR OF HYPOSPADIAS CRIPPLE REQUIRING EXTENSIVE DISSECTION AND EXCISION OF PREVIOUSLY CONSTRUCTED STRUCTURES INCLUDING RE-RELEASE OF CHORDEE AND RECONSTRUCTION OF URETHRA AND PENIS BY USE OF LOCAL SKIN AS GRAFTS AND ISLAND FLAPS AND SKIN BROUGHT IN AS F					
537	54360	PLASTIC OPERATION ON PENIS TO CORRECT ANGULATION					
537	54380	PLASTIC OPERATION ON PENIS FOR EPISPADIAS DISTAL TO EXTERNAL SPHINCTER;					
537	54385	PLASTIC OPERATION ON PENIS FOR EPISPADIAS DISTAL TO EXTERNAL SPHINCTER; WITH INCONTINENCE					
537	54402	REMOVAL OR REPLACEMENT OF NON-INFLATABLE (SEMI-RIGID) OR INFLATABLE (SELF-CONTAINED) PENILE PROSTHESIS					
537	54407	REMOVAL, REPAIR, OR REPLACEMENT OF INFLATABLE (MULTI-COMPONENT) PENILE PROSTHESIS, INCLUDING PUMP AND/OR RESERVOIR AND/OR CYLINDERS					
537	54409	SURGICAL CORRECTION OF HYDRAULIC ABNORMALITY OF INFLATABLE (MULTI-COMPONENT) PROSTHESIS INCLUDING PUMP AND/OR RESERVOIR AND/OR CYLINDERS					
537	54420	CORPORA CAVERNOSA-SAPHENOUS VEIN SHUNT (PRIAPISM OPERATION), UNILATERAL OR BILATERAL					
537	54435	CORPORA CAVERNOSA-GLANS PENIS FISTULIZATION (EG, BIOPSY NEEDLE, WINTER PROCEDURE, RONGEUR, OR PUNCH) FOR PRIAPISM					
537	54440	PLASTIC OPERATION OF PENIS FOR INJURY					
538	Insertion of Penile Prosthesis		T	45.59	$2,310.02	$1,540.64	$462.00
538	53440	OPERATION FOR CORRECTION OF MALE URINARY INCONTINENCE, WITH OR WITHOUT INTRODUCTION OF PROSTHESIS					
538	53445	OPERATION FOR CORRECTION OF URINARY INCONTINENCE WITH PLACEMENT OF INFLATABLE URETHRAL OR BLADDER NECK SPHINCTER, INCLUDING PLACEMENT OF PUMP AND/OR RESERVOIR					
538	54400	INSERTION OF PENILE PROSTHESIS; NON-INFLATABLE (SEMI-RIGID)					
538	54401	INSERTION OF PENILE PROSTHESIS; INFLATABLE (SELF-CONTAINED)					
538	54405	INSERTION OF INFLATABLE (MULTI-COMPONENT) PENILE PROSTHESIS, INCLUDING PLACEMENT OF PUMP, CYLINDERS, AND/OR RESERVOIR					
546	Testes/Epididymis Procedures		T	17.14	$868.47	$453.81	$173.69
546	54505	BIOPSY OF TESTIS, INCISIONAL (SEPARATE PROCEDURE)					
546	54510	EXCISION OF LOCAL LESION OF TESTIS					
546	54520	ORCHIECTOMY, SIMPLE (INCLUDING SUBCAPSULAR), WITH OR WITHOUT TESTICULAR PROSTHESIS, SCROTAL OR INGUINAL APPROACH					
546	54530	ORCHIECTOMY, RADICAL, FOR TUMOR; INGUINAL APPROACH					
546	54550	EXPLORATION FOR UNDESCENDED TESTIS (INGUINAL OR SCROTAL AREA)					
546	54600	REDUCTION OF TORSION OF TESTIS, SURGICAL, WITH OR WITHOUT FIXATION OF CONTRALATERAL TESTIS					
546	54620	FIXATION OF CONTRALATERAL TESTIS (SEPARATE PROCEDURE)					
546	54640	ORCHIOPEXY, INGUINAL APPROACH, WITH OR WITHOUT HERNIA REPAIR					
546	54660	INSERTION OF TESTICULAR PROSTHESIS (SEPARATE PROCEDURE)					
546	54670	SUTURE OR REPAIR OF TESTICULAR INJURY					
546	54680	TRANSPLANTATION OF TESTIS(ES) TO THIGH (BECAUSE OF SCROTAL DESTRUCTION)					
546	54700	INCISION AND DRAINAGE OF EPIDIDYMIS, TESTIS AND/OR SCROTAL SPACE (EG, ABSCESS OR HEMATOMA)					
546	54820	EXPLORATION OF EPIDIDYMIS, WITH OR WITHOUT BIOPSY					
546	54830	EXCISION OF LOCAL LESION OF EPIDIDYMIS					
546	54840	EXCISION OF SPERMATOCELE, WITH OR WITHOUT EPIDIDYMECTOMY					
546	54860	EPIDIDYMECTOMY; UNILATERAL					
546	54861	EPIDIDYMECTOMY; BILATERAL					

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
546	54900	EPIDIDYMOVASOSTOMY, ANASTOMOSIS OF EPIDIDYMIS TO VAS DEFERENS; UNILATERAL					
546	54901	EPIDIDYMOVASOSTOMY, ANASTOMOSIS OF EPIDIDYMIS TO VAS DEFERENS; BILATERAL					
546	55060	REPAIR OF TUNICA VAGINALIS HYDROCELE (BOTTLE TYPE)					
546	55110	SCROTAL EXPLORATION					
546	55120	REMOVAL OF FOREIGN BODY IN SCROTUM					
546	55150	RESECTION OF SCROTUM					
546	55175	SCROTOPLASTY; SIMPLE					
546	55180	SCROTOPLASTY; COMPLICATED					
546	55200	VASOTOMY, CANNULIZATION WITH OR WITHOUT INCISION OF VAS, UNILATERAL OR BILATERAL (SEPARATE PROCEDURE)					
546	55250	VASECTOMY, UNILATERAL OR BILATERAL (SEPARATE PROCEDURE), INCLUDING POSTOPERATIVE SEMEN EXAMINATION(S)					
546	55400	VASOVASOSTOMY, VASOVASORRHAPHY					
546	55450	LIGATION (PERCUTANEOUS) OF VAS DEFERENS, UNILATERAL OR BILATERAL (SEPARATE PROCEDURE)					
546	55500	EXCISION OF HYDROCELE OF SPERMATIC CORD, UNILATERAL (SEPARATE PROCEDURE)					
546	55520	EXCISION OF LESION OF SPERMATIC CORD (SEPARATE PROCEDURE)					
546	55530	EXCISION OF VARICOCELE OR LIGATION OF SPERMATIC VEINS FOR VARICOCELE; (SEPARATE PROCEDURE)					
546	55535	EXCISION OF VARICOCELE OR LIGATION OF SPERMATIC VEINS FOR VARICOCELE; ABDOMINAL APPROACH					
546	55540	EXCISION OF VARICOCELE OR LIGATION OF SPERMATIC VEINS FOR VARICOCELE; WITH HERNIA REPAIR					
546	55680	EXCISION OF MULLERIAN DUCT CYST					
547	Prostate Biopsy		T	4.39	$222.44	$125.2	$44.49
547	55700	BIOPSY, PROSTATE; NEEDLE OR PUNCH, SINGLE OR MULTIPLE, ANY APPROACH					
547	55705	BIOPSY, PROSTATE; INCISIONAL, ANY APPROACH					
550	Surgical Hysteroscopy		T	16.89	$855.81	$447.93	$171.16
550	56351	HYSTEROSCOPY, SURGICAL; WITH SAMPLING (BIOPSY) OF ENDOMETRIUM AND/OR POLYPECTOMY, WITH OR WITHOUT D & C					
550	56352	HYSTEROSCOPY, SURGICAL; WITH LYSIS OF INTRAUTERINE ADHESIONS (ANY METHOD)					
550	56353	HYSTEROSCOPY, SURGICAL; WITH DIVISION OR RESECTION OF INTRAUTERINE SEPTUM (ANY METHOD)					
550	56354	HYSTEROSCOPY, SURGICAL; WITH REMOVAL OF LEIOMYOMATA					
550	56355	HYSTEROSCOPY, SURGICAL; WITH REMOVAL OF IMPACTED FOREIGN BODY					
550	56356	HYSTEROSCOPY, SURGICAL; WITH ENDOMETRIAL ABLATION (ANY METHOD)					
551	Level I Laparoscopy		T	24.78	$1,255.59	$711.67	$251.12
551	56300	LAPAROSCOPY (PERITONEOSCOPY), DIAGNOSTIC; (SEPARATE PROCEDURE)					
551	56301	LAPAROSCOPY, SURGICAL; WITH FULGURATION OF OVIDUCTS (WITH OR WITHOUT TRANSECTION)					
551	56302	LAPAROSCOPY, SURGICAL; WITH OCCLUSION OF OVIDUCTS BY DEVICE (EG, BAND, CLIP, OR FALOPE RING)					
551	56303	LAPAROSCOPY, SURGICAL; WITH FULGURATION OR EXCISION OF LESIONS OF THE OVARY, PELVIC VISCERA, OR PERITONEAL SURFACE BY ANY METHOD					
551	56304	LAPAROSCOPY, SURGICAL; WITH LYSIS OF ADHESIONS (SALPINGOLYSIS, OVARIOLYSIS) (SEPARATE PROCEDURE)					
551	56305	LAPAROSCOPY, SURGICAL; WITH BIOPSY (SINGLE OR MULTIPLE)					
551	56306	LAPAROSCOPY, SURGICAL; WITH ASPIRATION (SINGLE OR MULTIPLE)					
551	56346	LAPAROSCOPY, SURGICAL; GASTROSTOMY, TEMPORARY (TUBE OR RUBBER OR PLASTIC) (SEPARATE PROCEDURE)					
552	Level II Laparoscopy		T	37.71	$1,910.75	$1,053.16	$382.15
552	56307	LAPAROSCOPY, SURGICAL; WITH REMOVAL OF ADNEXAL STRUCTURES (PARTIAL OR TOTAL OOPHORECTOMY AND/OR SALPINGECTOMY)					
552	56309	LAPAROSCOPY, SURGICAL; WITH REMOVAL OF LEIOMYOMATA (SINGLE OR MULTIPLE)					
552	56311	LAPAROSCOPY, SURGICAL; WITH RETROPERITONEAL LYMPH NODE SAMPLING (BIOPSY), SINGLE OR MULTIPLE					
552	56312	LAPAROSCOPY, SURGICAL; WITH BILATERAL TOTAL PELVIC LYMPHADENECTOMY					
552	56313	LAPAROSCOPY, SURGICAL; WITH BILATERAL TOTAL PELVIC LYMPHADENECTOMY AND PERI-AORTIC LYMPH NODE SAMPLING (BIOPSY), SINGLE OR MULTIPLE					
552	56316	LAPAROSCOPY, SURGICAL; REPAIR OF INITIAL INGUINAL HERNIA					
552	56317	LAPAROSCOPY, SURGICAL; REPAIR OF RECURRENT INGUINAL HERNIA					
552	56318	LAPAROSCOPY, SURGICAL; ORCHIECTOMY					
552	56320	LAPAROSCOPY, SURGICAL; WITH LIGATION OF SPERMATIC VEINS FOR VARICOCELE					
552	56343	LAPAROSCOPY, SURGICAL; WITH SALPINGOSTOMY (SALPINGONEOSTOMY)					
552	56344	LAPAROSCOPY, SURGICAL; WITH FIMBRIOPLASTY					
552	56362	LAPAROSCOPY WITH GUIDED TRANSHEPATIC CHOLANGIOGRAPHY; WITHOUT BIOPSY					
552	56363	LAPAROSCOPY WITH GUIDED TRANSHEPATIC CHOLANGIOGRAPHY; WITH BIOPSY					
561	Level I Female Reproductive Procedures		T	1.52	$77.02	$24.63	$15.4
561	56405	INCISION AND DRAINAGE OF VULVA OR PERINEAL ABSCESS					
561	56420	INCISION AND DRAINAGE OF BARTHOLIN'S GLAND ABSCESS					
561	56441	LYSIS OF LABIAL ADHESIONS					
561	57061	DESTRUCTION OF VAGINAL LESION(S); SIMPLE, ANY METHOD					
561	57100	BIOPSY OF VAGINAL MUCOSA; SIMPLE (SEPARATE PROCEDURE)					
561	57150	IRRIGATION OF VAGINA AND/OR APPLICATION OF MEDICAMENT FOR TREATMENT OF BACTERIAL, PARASITIC, OR FUNGOID DISEASE					
561	57160	FITTING AND INSERTION OF PESSARY OR OTHER INTRAVAGINAL SUPPORT DEVICE					
561	57170	DIAPHRAGM OR CERVICAL CAP FITTING WITH INSTRUCTIONS					
561	57180	INTRODUCTION OF ANY HEMOSTATIC AGENT OR PACK FOR SPONTANEOUS OR TRAUMATIC NONOBSTETRICAL VAGINAL HEMORRHAGE (SEPARATE PROCEDURE)					
561	57452	COLPOSCOPY (VAGINOSCOPY); (SEPARATE PROCEDURE)					
561	57454	COLPOSCOPY (VAGINOSCOPY); WITH BIOPSY(S) OF THE CERVIX AND/OR ENDOCERVICAL CURETTAGE					
561	57500	BIOPSY, SINGLE OR MULTIPLE, OR LOCAL EXCISION OF LESION, WITH OR WITHOUT FULGURATION (SEPARATE PROCEDURE)					
561	57505	ENDOCERVICAL CURETTAGE (NOT DONE AS PART OF A DILATION AND CURETTAGE)					
561	57510	CAUTERIZATION OF CERVIX; ELECTRO OR THERMAL					
561	57511	CAUTERIZATION OF CERVIX; CRYOCAUTERY, INITIAL OR REPEAT					
561	57513	CAUTERIZATION OF CERVIX; LASER ABLATION					

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
561	57800	DILATION OF CERVICAL CANAL, INSTRUMENTAL (SEPARATE PROCEDURE)					
561	58100	ENDOMETRIAL SAMPLING (BIOPSY) WITH OR WITHOUT ENDOCERVICAL SAMPLING (BIOPSY), WITHOUT CERVICAL DILATION, ANY METHOD (SEPARATE PROCEDURE)					
561	58301	REMOVAL OF INTRAUTERINE DEVICE (IUD)					
561	59200	INSERTION OF CERVICAL DILATOR (EG, LAMINARIA, PROSTAGLANDIN) (SEPARATE PROCEDURE)					
562	Level II Female Reproductive Procedures		T	12.76	$646.54	$330.75	$129.31
562	56350	HYSTEROSCOPY, DIAGNOSTIC (SEPARATE PROCEDURE)					
562	56399	UNLISTED PROCEDURE, LAPAROSCOPY, HYSTEROSCOPY					
562	56440	MARSUPIALIZATION OF BARTHOLIN'S GLAND CYST					
562	56700	PARTIAL HYMENECTOMY OR REVISION OF HYMENAL RING					
562	56720	HYMENOTOMY, SIMPLE INCISION					
562	56740	EXCISION OF BARTHOLIN'S GLAND OR CYST					
562	56800	PLASTIC REPAIR OF INTROITUS					
562	56810	PERINEOPLASTY, REPAIR OF PERINEUM, NONOBSTETRICAL (SEPARATE PROCEDURE)					
562	57000	COLPOTOMY; WITH EXPLORATION					
562	57010	COLPOTOMY; WITH DRAINAGE OF PELVIC ABSCESS					
562	57020	COLPOCENTESIS (SEPARATE PROCEDURE)					
562	57065	DESTRUCTION OF VAGINAL LESION(S); EXTENSIVE, ANY METHOD					
562	57105	BIOPSY OF VAGINAL MUCOSA; EXTENSIVE, REQUIRING SUTURE (INCLUDING CYSTS)					
562	57130	EXCISION OF VAGINAL SEPTUM					
562	57135	EXCISION OF VAGINAL CYST OR TUMOR					
562	57200	COLPORRHAPHY, SUTURE OF INJURY OF VAGINA (NONOBSTETRICAL)					
562	57210	COLPOPERINEORRHAPHY, SUTURE OF INJURY OF VAGINA AND/OR PERINEUM (NONOBSTETRICAL)					
562	57230	PLASTIC REPAIR OF URETHROCELE					
562	57400	DILATION OF VAGINA UNDER ANESTHESIA					
562	57410	PELVIC EXAMINATION UNDER ANESTHESIA					
562	57415	REMOVAL OF IMPACTED VAGINAL FOREIGN BODY (SEPARATE PROCEDURE) UNDER ANESTHESIA					
562	57460	COLPOSCOPY (VAGINOSCOPY); WITH LOOP ELECTRODE EXCISION PROCEDURE OF THE CERVIX					
562	57700	CERCLAGE OF UTERINE CERVIX, NONOBSTETRICAL					
562	57720	TRACHELORRHAPHY, PLASTIC REPAIR OF UTERINE CERVIX, VAGINAL APPROACH					
562	58345	TRANSCERVICAL INTRODUCTION OF FALLOPIAN TUBE CATHETER FOR DIAGNOSIS AND/OR RE-ESTABLISHING PATENCY (ANY METHOD), WITH OR WITHOUT HYSTEROSALPINGOGRAPHY					
562	58350	CHROMOTUBATION OF OVIDUCT, INCLUDING MATERIALS					
562	58970	FOLLICLE PUNCTURE FOR OOCYTE RETRIEVAL, ANY METHOD					
562	59300	EPISIOTOMY OR VAGINAL REPAIR, BY OTHER THAN ATTENDING PHYSICIAN					
562	59320	CERCLAGE OF CERVIX, DURING PREGNANCY; VAGINAL					
562	59871	REMOVAL OF CERCLAGE SUTURE UNDER ANESTHESIA (OTHER THAN LOCAL)					
563	Level III Female Reproductive Procedures		T	16.90	$856.31	$464.88	$171.26
563	56620	VULVECTOMY SIMPLE; PARTIAL					
563	56625	VULVECTOMY SIMPLE; COMPLETE					
563	57220	PLASTIC OPERATION ON URETHRAL SPHINCTER, VAGINAL APPROACH (EG, KELLY URETHRAL PLICATION)					
563	57240	ANTERIOR COLPORRHAPHY, REPAIR OF CYSTOCELE WITH OR WITHOUT REPAIR OF URETHROCELE					
563	57250	POSTERIOR COLPORRHAPHY, REPAIR OF RECTOCELE WITH OR WITHOUT PERINEORRHAPHY					
563	57260	COMBINED ANTEROPOSTERIOR COLPORRHAPHY;					
563	57265	COMBINED ANTEROPOSTERIOR COLPORRHAPHY; WITH ENTEROCELE REPAIR					
563	57268	REPAIR OF ENTEROCELE, VAGINAL APPROACH (SEPARATE PROCEDURE)					
563	57284	PARAVAGINAL DEFECT REPAIR (INCLUDING REPAIR OF CYSTOCELE, STRESS URINARY INCONTINENCE, AND/OR INCOMPLETE VAGINAL PROLAPSE)					
563	57288	SLING OPERATION FOR STRESS INCONTINENCE (EG, FASCIA OR SYNTHETIC)					
563	57289	PEREYRA PROCEDURE, INCLUDING ANTERIOR COLPORRHAPHY					
563	57291	CONSTRUCTION OF ARTIFICIAL VAGINA; WITHOUT GRAFT					
563	57300	CLOSURE OF RECTOVAGINAL FISTULA; VAGINAL OR TRANSANAL APPROACH					
563	57520	CONIZATION OF CERVIX, WITH OR WITHOUT FULGURATION, WITH OR WITHOUT DILATION AND CURETTAGE, WITH OR WITHOUT REPAIR; COLD KNIFE OR LASER					
563	57522	CONIZATION OF CERVIX, WITH OR WITHOUT FULGURATION, WITH OR WITHOUT DILATION AND CURETTAGE, WITH OR WITHOUT REPAIR; LOOP ELECTRODE EXCISION					
563	57530	TRACHELECTOMY (CERVICECTOMY), AMPUTATION OF CERVIX (SEPARATE PROCEDURE)					
563	57550	EXCISION OF CERVICAL STUMP, VAGINAL APPROACH;					
563	57555	EXCISION OF CERVICAL STUMP, VAGINAL APPROACH; WITH ANTERIOR AND/OR POSTERIOR REPAIR					
563	57556	EXCISION OF CERVICAL STUMP, VAGINAL APPROACH; WITH REPAIR OF ENTEROCELE					
563	58145	MYOMECTOMY, EXCISION OF FIBROID TUMOR OF UTERUS, SINGLE OR MULTIPLE (SEPARATE PROCEDURE); VAGINAL APPROACH					
563	58800	DRAINAGE OF OVARIAN CYST(S), UNILATERAL OR BILATERAL, (SEPARATE PROCEDURE); VAGINAL APPROACH					
563	58820	DRAINAGE OF OVARIAN ABSCESS; VAGINAL APPROACH, OPEN					
567	D & C		T	13.61	$689.61	$364.09	$137.92
567	57820	DILATION AND CURETTAGE OF CERVICAL STUMP					
567	58120	DILATION AND CURETTAGE, DIAGNOSTIC AND/OR THERAPEUTIC (NONOBSTETRICAL)					
567	59160	CURRETTAGE, POSTPARTUM					
568	Infertility Procedures		T	2.49	$126.17	$49.49	$25.23
568	55870	ELECTROEJACULATION					
568	58321	ARTIFICIAL INSEMINATION; INTRA-CERVICAL					
568	58322	ARTIFICIAL INSEMINATION; INTRA-UTERINE					
568	58323	SPERM WASHING FOR ARTIFICIAL INSEMINATION					
568	58974	EMBRYO TRANSFER, INTRAUTERINE					

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
568	58976	GAMETE, ZYGOTE, OR EMBRYO INTRAFALLOPIAN TRANSFER, ANY METHOD					
578	Pregnancy and Neonatal Care Procedures		T	1.26	$63.84	$33.9	$12.77
578	59000	AMNIOCENTESIS, ANY METHOD					
578	59012	CORDOCENTESIS (INTRAUTERINE), ANY METHOD					
578	59015	CHORIONIC VILLUS SAMPLING, ANY METHOD					
578	59020	FETAL CONTRACTION STRESS TEST					
578	59025	FETAL NON-STRESS TEST					
578	59030	FETAL SCALP BLOOD SAMPLING					
578	59050	FETAL MONITORING DURING LABOR BY CONSULTING PHYSICIAN (IE, NON-ATTENDING PHYSICIAN) WITH WRITTEN REPORT; SUPERVISION AND INTERPRETATION					
578	59899	UNLISTED PROCEDURE, MATERNITY CARE AND DELIVERY					
580	Vaginal Delivery		T	4.59	$232.57	$146.34	$46.51
580	59409	VAGINAL DELIVERY ONLY (WITH OR WITHOUT EPISIOTOMY AND/OR FORCEPS);					
580	59412	EXTERNAL CEPHALIC VERSION, WITH OR WITHOUT TOCOLYSIS (LIST IN ADDITION TO CODE(S) FOR DELIVERY)					
580	59414	DELIVERY OF PLACENTA (SEPARATE PROCEDURE)					
580	59612	VAGINAL DELIVERY ONLY, AFTER PREVIOUS CESAREAN DELIVERY (WITH OR WITHOUT EPISIOTOMY AND/OR FORCEPS);					
586	Therapeutic Abortion		T	12.5	$633.37	$431.89	$126.67
586	59840	INDUCED ABORTION, BY DILATION AND CURETTAGE					
586	59841	INDUCED ABORTION, BY DILATION AND EVACUATION					
587	Spontaneous Abortion		T	13.25	$671.37	$347.02	$134.27
587	59812	TREATMENT OF INCOMPLETE ABORTION, ANY TRIMESTER, COMPLETED SURGICALLY					
587	59820	TREATMENT OF MISSED ABORTION, COMPLETED SURGICALLY; FIRST TRIMESTER					
587	59821	TREATMENT OF MISSED ABORTION, COMPLETED SURGICALLY; SECOND TRIMESTER					
587	59870	UTERINE EVACUATION AND CURETTAGE FOR HYDATIDIFORM MOLE					
600	Spinal Tap		T	2.63	$133.26	$61.47	$26.65
600	62270	SPINAL PUNCTURE, LUMBAR, DIAGNOSTIC					
600	62272	SPINAL PUNCTURE, THERAPEUTIC, FOR DRAINAGE OF SPINAL FLUID (BY NEEDLE OR CATHETER)					
601	Level I Nervous System Injections		T	3.11	$157.58	$74.13	$31.52
601	64400	INJECTION, ANESTHETIC AGENT; TRIGEMINAL NERVE, ANY DIVISION OR BRANCH					
601	64402	INJECTION, ANESTHETIC AGENT; FACIAL NERVE					
601	64405	INJECTION, ANESTHETIC AGENT; GREATER OCCIPITAL NERVE					
601	64408	INJECTION, ANESTHETIC AGENT; VAGUS NERVE					
601	64410	INJECTION, ANESTHETIC AGENT; PHRENIC NERVE					
601	64412	INJECTION, ANESTHETIC AGENT; SPINAL ACCESSORY NERVE					
601	64413	INJECTION, ANESTHETIC AGENT; CERVICAL PLEXUS					
601	64415	INJECTION, ANESTHETIC AGENT; BRACHIAL PLEXUS					
601	64417	INJECTION, ANESTHETIC AGENT; AXILLARY NERVE					
601	64418	INJECTION, ANESTHETIC AGENT; SUPRASCAPULAR NERVE					
601	64420	INJECTION, ANESTHETIC AGENT; INTERCOSTAL NERVE, SINGLE					
601	64421	INJECTION, ANESTHETIC AGENT; INTERCOSTAL NERVES, MULTIPLE, REGIONAL BLOCK					
601	64425	INJECTION, ANESTHETIC AGENT; ILIOINGUINAL, ILIOHYPOGASTRIC NERVES					
601	64430	INJECTION, ANESTHETIC AGENT; PUDENDAL NERVE					
601	64435	INJECTION, ANESTHETIC AGENT; PARACERVICAL (UTERINE) NERVE					
601	64440	INJECTION, ANESTHETIC AGENT; PARAVERTEBRAL NERVE (THORACIC, LUMBAR, SACRAL, COCCYGEAL), SINGLE VERTEBRAL LEVEL					
601	64441	INJECTION, ANESTHETIC AGENT; PARAVERTEBRAL NERVES, MULTIPLE LEVELS (EG, REGIONAL BLOCK)					
601	64442	INJECTION, ANESTHETIC AGENT; PARAVERTEBRAL FACET JOINT NERVE, LUMBAR, SINGLE LEVEL					
601	64443	INJECTION, ANESTHETIC AGENT; PARAVERTEBRAL FACET JOINT NERVE, LUMBAR, EACH ADDITIONAL LEVEL					
601	64445	INJECTION, ANESTHETIC AGENT; SCIATIC NERVE					
601	64450	INJECTION, ANESTHETIC AGENT; OTHER PERIPHERAL NERVE OR BRANCH					
601	64505	INJECTION, ANESTHETIC AGENT; SPHENOPALATINE GANGLION					
601	64508	INJECTION, ANESTHETIC AGENT; CAROTID SINUS (SEPARATE PROCEDURE)					
601	64510	INJECTION, ANESTHETIC AGENT; STELLATE GANGLION (CERVICAL SYMPATHETIC)					
601	64520	INJECTION, ANESTHETIC AGENT; LUMBAR OR THORACIC (PARAVERTEBRAL SYMPATHETIC)					
601	64530	INJECTION, ANESTHETIC AGENT; CELIAC PLEXUS, WITH OR WITHOUT RADIOLOGIC MONITORING					
601	64600	DESTRUCTION BY NEUROLYTIC AGENT, TRIGEMINAL NERVE; SUPRAORBITAL, INFRAORBITAL, MENTAL, OR INFERIOR ALVEOLAR BRANCH					
601	64605	DESTRUCTION BY NEUROLYTIC AGENT, TRIGEMINAL NERVE; SECOND AND THIRD DIVISION BRANCHES AT FORAMEN OVALE					
601	64610	DESTRUCTION BY NEUROLYTIC AGENT, TRIGEMINAL NERVE; SECOND AND THIRD DIVISION BRANCHES AT FORAMEN OVALE UNDER RADIOLOGIC MONITORING					
601	64612	DESTRUCTION BY NEUROLYTIC AGENT (CHEMODENERVATION OF MUSCLE ENDPLATE); MUSCLES ENERVATED BY FACIAL NERVE (EG, FOR BLEPHAROSPASM, HEMIFACIAL SPASM)					
601	64613	DESTRUCTION BY NEUROLYTIC AGENT (CHEMODENERVATION OF MUSCLE ENDPLATE); CERVICAL SPINAL MUSCLES (EG, FOR SPASMODIC TORTICOLLIS)					
601	64620	DESTRUCTION BY NEUROLYTIC AGENT; INTERCOSTAL NERVE					
601	64622	DESTRUCTION BY NEUROLYTIC AGENT; PARAVERTEBRAL FACET JOINT NERVE, LUMBAR, SINGLE LEVEL					
601	64623	DESTRUCTION BY NEUROLYTIC AGENT; PARAVERTEBRAL FACET JOINT NERVE, LUMBAR, EACH ADDITIONAL LEVEL					
601	64630	DESTRUCTION BY NEUROLYTIC AGENT; PUDENDAL NERVE					
601	64640	DESTRUCTION BY NEUROLYTIC AGENT; OTHER PERIPHERAL NERVE OR BRANCH					
601	64680	DESTRUCTION BY NEUROLYTIC AGENT, CELIAC PLEXUS, WITH OR WITHOUT RADIOLOGIC MONITORING					
601	64999	UNLISTED PROCEDURE, NERVOUS SYSTEM					
602	Level II Nervous System Injections		T	3.33	$168.73	$87.69	$33.75

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
602	61000	SUBDURAL TAP THROUGH FONTANELLE, OR SUTURE, INFANT, UNILATERAL OR BILATERAL; INITIAL					
602	61001	SUBDURAL TAP THROUGH FONTANELLE, OR SUTURE, INFANT, UNILATERAL OR BILATERAL; SUBSEQUENT TAPS					
602	61020	VENTRICULAR PUNCTURE THROUGH PREVIOUS BURR HOLE, FONTANELLE, SUTURE, OR IMPLANTED VENTRICULAR CATHETER/RESERVOIR; WITHOUT INJECTION					
602	61026	VENTRICULAR PUNCTURE THROUGH PREVIOUS BURR HOLE, FONTANELLE, SUTURE, OR IMPLANTED VENTRICULAR CATHETER/RESERVOIR; WITH INJECTION OF DRUG OR OTHER SUBSTANCE FOR DIAGNOSIS OR TREATMENT					
602	61050	CISTERNAL OR LATERAL CERVICAL (C1-C2) PUNCTURE; WITHOUT INJECTION (SEPARATE PROCEDURE)					
602	61055	CISTERNAL OR LATERAL CERVICAL (C1-C2) PUNCTURE; WITH INJECTION OF DRUG OR OTHER SUBSTANCE FOR DIAGNOSIS OR TREATMENT (EG, C1-C2)					
602	61070	PUNCTURE OF SHUNT TUBING OR RESERVOIR FOR ASPIRATION OR INJECTION PROCEDURE					
602	62194	REPLACEMENT OR IRRIGATION, SUBARACHNOID/SUBDURAL CATHETER					
602	62225	REPLACEMENT OR IRRIGATION, VENTRICULAR CATHETER					
602	62268	PERCUTANEOUS ASPIRATION, SPINAL CORD CYST OR SYRINX					
602	62273	INJECTION, LUMBAR EPIDURAL, OF BLOOD OR CLOT PATCH					
602	62274	INJECTION OF DIAGNOSTIC OR THERAPEUTIC ANESTHETIC OR ANTISPASMODIC SUBSTANCE (INCLUDING NARCOTICS); SUBARACHNOID OR SUBDURAL, SINGLE					
602	62275	INJECTION OF DIAGNOSTIC OR THERAPEUTIC ANESTHETIC OR ANTISPASMODIC SUBSTANCE (INCLUDING NARCOTICS); EPIDURAL, CERVICAL OR THORACIC, SINGLE					
602	62276	INJECTION OF DIAGNOSTIC OR THERAPEUTIC ANESTHETIC OR ANTISPASMODIC SUBSTANCE (INCLUDING NARCOTICS); SUBARACHNOID OR SUBDURAL, DIFFERENTIAL					
602	62277	INJECTION OF DIAGNOSTIC OR THERAPEUTIC ANESTHETIC OR ANTISPASMODIC SUBSTANCE (INCLUDING NARCOTICS); SUBARACHNOID OR SUBDURAL, CONTINUOUS					
602	62278	INJECTION OF DIAGNOSTIC OR THERAPEUTIC ANESTHETIC OR ANTISPASMODIC SUBSTANCE (INCLUDING NARCOTICS); EPIDURAL, LUMBAR OR CAUDAL, SINGLE					
602	62279	INJECTION OF DIAGNOSTIC OR THERAPEUTIC ANESTHETIC OR ANTISPASMODIC SUBSTANCE (INCLUDING NARCOTICS); EPIDURAL, LUMBAR OR CAUDAL, CONTINUOUS					
602	62280	INJECTION OF NEUROLYTIC SUBSTANCE (EG, ALCOHOL, PHENOL, ICED SALINE SOLUTIONS); SUBARACHNOID					
602	62281	INJECTION OF NEUROLYTIC SUBSTANCE (EG, ALCOHOL, PHENOL, ICED SALINE SOLUTIONS); EPIDURAL, CERVICAL OR THORACIC					
602	62282	INJECTION OF NEUROLYTIC SUBSTANCE (EG, ALCOHOL, PHENOL, ICED SALINE SOLUTIONS); EPIDURAL, LUMBAR OR CAUDAL					
602	62288	INJECTION OF SUBSTANCE OTHER THAN ANESTHETIC, ANTISPASMODIC, CONTRAST, OR NEUROLYTIC SOLUTIONS; SUBARACHNOID (SEPARATE PROCEDURE)					
602	62289	INJECTION OF SUBSTANCE OTHER THAN ANESTHETIC, ANTISPASMODIC, CONTRAST, OR NEUROLYTIC SOLUTIONS; LUMBAR OR CAUDAL EPIDURAL (SEPARATE PROCEDURE)					
602	62292	INJECTION PROCEDURE FOR CHEMONUCLEOLYSIS, INCLUDING DISKOGRAPHY, INTERVERTEBRAL DISK, SINGLE OR MULTIPLE LEVELS, LUMBAR					
602	62294	INJECTION PROCEDURE, ARTERIAL, FOR OCCLUSION OF ARTERIOVENOUS MALFORMATION, SPINAL					
602	62298	INJECTION OF SUBSTANCE OTHER THAN ANESTHETIC, CONTRAST, OR NEUROLYTIC SOLUTIONS, EPIDURAL, CERVICAL OR THORACIC (SEPARATE PROCEDURE)					
616		Implantation of Neurostimulator Electrodes	T	14.43	$731.16	$366.57	$146.23
616	63650	PERCUTANEOUS IMPLANTATION OF NEUROSTIMULATOR ELECTRODES; EPIDURAL					
616	64553	PERCUTANEOUS IMPLANTATION OF NEUROSTIMULATOR ELECTRODES; CRANIAL NERVE					
616	64555	PERCUTANEOUS IMPLANTATION OF NEUROSTIMULATOR ELECTRODES; PERIPHERAL NERVE					
616	64560	PERCUTANEOUS IMPLANTATION OF NEUROSTIMULATOR ELECTRODES; AUTONOMIC NERVE					
616	64565	PERCUTANEOUS IMPLANTATION OF NEUROSTIMULATOR ELECTRODES; NEUROMUSCULAR					
616	64573	INCISION FOR IMPLANTATION OF NEUROSTIMULATOR ELECTRODES; CRANIAL NERVE					
616	64575	INCISION FOR IMPLANTATION OF NEUROSTIMULATOR ELECTRODES; PERIPHERAL NERVE					
616	64577	INCISION FOR IMPLANTATION OF NEUROSTIMULATOR ELECTRODES; AUTONOMIC NERVE					
616	64580	INCISION FOR IMPLANTATION OF NEUROSTIMULATOR ELECTRODES; NEUROMUSCULAR					
617		Revision/Removal Neurological Device	T	11.56	$585.74	$287.59	$117.15
617	62230	REPLACEMENT OR REVISION OF CSF SHUNT, OBSTRUCTED VALVE, OR DISTAL CATHETER IN SHUNT SYSTEM					
617	62350	IMPLANTATION, REVISION OR REPOSITIONING OF INTRATHECAL OR EPIDURAL CATHETER, FOR IMPLANTABLE RESERVOIR OR IMPLANTABLE INFUSION PUMP; WITHOUT LAMINECTOMY					
617	62355	REMOVAL OF PREVIOUSLY IMPLANTED INTRATHECAL OR EPIDURAL CATHETER					
617	62365	REMOVAL OF SUBCUTANEOUS RESERVOIR OR PUMP, PREVIOUSLY IMPLANTED FOR INTRATHECAL OR EPIDURAL INFUSION					
617	63660	REVISION OR REMOVAL OF SPINAL NEUROSTIMULATOR ELECTRODES					
617	63688	REVISION OR REMOVAL OF IMPLANTED SPINAL NEUROSTIMULATOR PULSE GENERATOR OR RECEIVER					
617	63744	REPLACEMENT, IRRIGATION OR REVISION OF LUMBOSUBARACHNOID SHUNT					
617	63746	REMOVAL OF ENTIRE LUMBOSUBARACHNOID SHUNT SYSTEM WITHOUT REPLACEMENT					
617	64585	REVISION OR REMOVAL OF PERIPHERAL NEUROSTIMULATOR ELECTRODES					
617	64595	REVISION OR REMOVAL OF PERIPHERAL NEUROSTIMULATOR PULSE GENERATOR OR RECEIVER					
618		Implantation of Neurological Device	T	25.56	$1,295.11	$780.49	$259.02
618	61215	INSERTION OF SUBCUTANEOUS RESERVOIR, PUMP OR CONTINUOUS INFUSION SYSTEM FOR CONNECTION TO VENTRICULAR CATHETER					
618	61885	INCISION AND SUBCUTANEOUS PLACEMENT OF CRANIAL NEUROSTIMULATOR PULSE GENERATOR OR RECEIVER, DIRECT OR INDUCTIVE COUPLING					
618	62360	IMPLANTATION OR REPLACEMENT OF DEVICE FOR INTRATHECAL OR EPIDURAL DRUG INFUSION; SUBCUTANEOUS RESERVOIR					
618	62361	IMPLANTATION OR REPLACEMENT OF DEVICE FOR INTRATHECAL OR EPIDURAL DRUG INFUSION; NON-PROGRAMMABLE PUMP					
618	62362	IMPLANTATION OR REPLACEMENT OF DEVICE FOR INTRATHECAL OR EPIDURAL DRUG INFUSION; PROGRAMMABLE PUMP, INCLUDING PREPARATION OF PUMP, WITH OR WITHOUT PROGRAMMING					
618	63685	INCISION AND SUBCUTANEOUS PLACEMENT OF SPINAL NEUROSTIMULATOR PULSE GENERATOR OR RECEIVER, DIRECT OR INDUCTIVE COUPLING					
618	64590	INCISION AND SUBCUTANEOUS PLACEMENT OF PERIPHERAL NEUROSTIMULATOR PULSE GENERATOR OR RECEIVER, DIRECT OR INDUCTIVE COUPLING					

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
631	Level I Nerve Procedures		T	12.98	$657.69	$333.8	$131.54
631	27315	NEURECTOMY, HAMSTRING MUSCLE					
631	27320	NEURECTOMY, POPLITEAL (GASTROCNEMIUS)					
631	28030	NEURECTOMY OF INTRINSIC MUSCULATURE OF FOOT					
631	28035	TARSAL TUNNEL RELEASE (POSTERIOR TIBIAL NERVE DECOMPRESSION)					
631	61790	CREATION OF LESION BY STEREOTACTIC METHOD, PERCUTANEOUS, BY NEUROLYTIC AGENT (EG, ALCOHOL, THERMAL, ELECTRICAL, RADIOFREQUENCY); GASSERIAN GANGLION					
631	62287	ASPIRATION PROCEDURE, PERCUTANEOUS, OF NUCLEUS PULPOSUS OF INTERVERTEBRAL DISK, ANY METHOD, SINGLE OR MULTIPLE LEVELS, LUMBAR					
631	63600	CREATION OF LESION OF SPINAL CORD BY STEREOTACTIC METHOD, PERCUTANEOUS, ANY MODALITY (INCLUDING STIMULATION AND/OR RECORDING)					
631	63610	STEREOTACTIC STIMULATION OF SPINAL CORD, PERCUTANEOUS, SEPARATE PROCEDURE NOT FOLLOWED BY OTHER SURGERY					
631	63615	STEREOTACTIC BIOPSY, ASPIRATION, OR EXCISION OF LESION, SPINAL CORD					
631	64702	NEUROPLASTY; DIGITAL, ONE OR BOTH, SAME DIGIT					
631	64704	NEUROPLASTY; NERVE OF HAND OR FOOT					
631	64708	NEUROPLASTY, MAJOR PERIPHERAL NERVE, ARM OR LEG; OTHER THAN SPECIFIED					
631	64712	NEUROPLASTY, MAJOR PERIPHERAL NERVE, ARM OR LEG; SCIATIC NERVE					
631	64713	NEUROPLASTY, MAJOR PERIPHERAL NERVE, ARM OR LEG; BRACHIAL PLEXUS					
631	64714	NEUROPLASTY, MAJOR PERIPHERAL NERVE, ARM OR LEG; LUMBAR PLEXUS					
631	64716	NEUROPLASTY AND/OR TRANSPOSITION; CRANIAL NERVE (SPECIFY)					
631	64718	NEUROPLASTY AND/OR TRANSPOSITION; ULNAR NERVE AT ELBOW					
631	64719	NEUROPLASTY AND/OR TRANSPOSITION; ULNAR NERVE AT WRIST					
631	64721	NEUROPLASTY AND/OR TRANSPOSITION; MEDIAN NERVE AT CARPAL TUNNEL					
631	64722	DECOMPRESSION; UNSPECIFIED NERVE(S) (SPECIFY)					
631	64726	DECOMPRESSION; PLANTAR DIGITAL NERVE					
631	64727	INTERNAL NEUROLYSIS, REQUIRING USE OF OPERATING MICROSCOPE (LIST SEPARATELY IN ADDITION TO CODE FOR NEUROPLASTY) (NEUROPLASTY INCLUDES EXTERNAL NEUROLYSIS)					
631	64732	TRANSECTION OR AVULSION OF; SUPRAORBITAL NERVE					
631	64734	TRANSECTION OR AVULSION OF; INFRAORBITAL NERVE					
631	64736	TRANSECTION OR AVULSION OF; MENTAL NERVE					
631	64738	TRANSECTION OR AVULSION OF; INFERIOR ALVEOLAR NERVE BY OSTEOTOMY					
631	64740	TRANSECTION OR AVULSION OF; LINGUAL NERVE					
631	64742	TRANSECTION OR AVULSION OF; FACIAL NERVE, DIFFERENTIAL OR COMPLETE					
631	64744	TRANSECTION OR AVULSION OF; GREATER OCCIPITAL NERVE					
631	64746	TRANSECTION OR AVULSION OF; PHRENIC NERVE					
631	64761	TRANSECTION OR AVULSION OF; PUDENDAL NERVE					
631	64771	TRANSECTION OR AVULSION OF OTHER CRANIAL NERVE, EXTRADURAL					
631	64772	TRANSECTION OR AVULSION OF OTHER SPINAL NERVE, EXTRADURAL					
631	64774	EXCISION OF NEUROMA; CUTANEOUS NERVE, SURGICALLY IDENTIFIABLE					
631	64776	EXCISION OF NEUROMA; DIGITAL NERVE, ONE OR BOTH, SAME DIGIT					
631	64778	EXCISION OF NEUROMA; DIGITAL NERVE, EACH ADDITIONAL DIGIT (LIST SEPARATELY BY THIS NUMBER)					
631	64782	EXCISION OF NEUROMA; HAND OR FOOT, EXCEPT DIGITAL NERVE					
631	64783	EXCISION OF NEUROMA; HAND OR FOOT, EACH ADDITIONAL NERVE, EXCEPT SAME DIGIT (LIST SEPARATELY BY THIS NUMBER)					
631	64784	EXCISION OF NEUROMA; MAJOR PERIPHERAL NERVE, EXCEPT SCIATIC					
631	64787	IMPLANTATION OF NERVE END INTO BONE OR MUSCLE (LIST SEPARATELY IN ADDITION TO NEUROMA EXCISION)					
631	64788	EXCISION OF NEUROFIBROMA OR NEUROLEMMOMA; CUTANEOUS NERVE					
631	64790	EXCISION OF NEUROFIBROMA OR NEUROLEMMOMA; MAJOR PERIPHERAL NERVE					
631	64795	BIOPSY OF NERVE					
631	64830	MICRODISSECTION AND/OR MICROREPAIR OF NERVE (LIST SEPARATELY IN ADDITION TO CODE FOR NERVE REPAIR)					
632	Level II Nerve Procedures		T	18.13	$918.64	$461.04	$183.73
632	64786	EXCISION OF NEUROMA; SCIATIC NERVE					
632	64792	EXCISION OF NEUROFIBROMA OR NEUROLEMMOMA; EXTENSIVE (INCLUDING MALIGNANT TYPE)					
632	64831	SUTURE OF DIGITAL NERVE, HAND OR FOOT; ONE NERVE					
632	64832	SUTURE OF DIGITAL NERVE, HAND OR FOOT; EACH ADDITIONAL DIGITAL NERVE					
632	64834	SUTURE OF ONE NERVE, HAND OR FOOT; COMMON SENSORY NERVE					
632	64835	SUTURE OF ONE NERVE, HAND OR FOOT; MEDIAN MOTOR THENAR					
632	64836	SUTURE OF ONE NERVE, HAND OR FOOT; ULNAR MOTOR					
632	64837	SUTURE OF EACH ADDITIONAL NERVE, HAND OR FOOT					
632	64840	SUTURE OF POSTERIOR TIBIAL NERVE					
632	64856	SUTURE OF MAJOR PERIPHERAL NERVE, ARM OR LEG, EXCEPT SCIATIC; INCLUDING TRANSPOSITION					
632	64857	SUTURE OF MAJOR PERIPHERAL NERVE, ARM OR LEG, EXCEPT SCIATIC; WITHOUT TRANSPOSITION					
632	64858	SUTURE OF SCIATIC NERVE					
632	64859	SUTURE OF EACH ADDITIONAL MAJOR PERIPHERAL NERVE					
632	64861	SUTURE OF; BRACHIAL PLEXUS					
632	64862	SUTURE OF; LUMBAR PLEXUS					
632	64864	SUTURE OF FACIAL NERVE; EXTRACRANIAL					
632	64865	SUTURE OF FACIAL NERVE; INFRATEMPORAL, WITH OR WITHOUT GRAFTING					
632	64870	ANASTOMOSIS; FACIAL-PHRENIC					
632	64872	SUTURE OF NERVE; REQUIRING SECONDARY OR DELAYED SUTURE (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY NEURORRHAPHY)					
632	64874	SUTURE OF NERVE; REQUIRING EXTENSIVE MOBILIZATION, OR TRANSPOSITION OF NERVE (LIST SEPARATELY IN ADDITION TO CODE FOR NERVE SUTURE)					
632	64876	SUTURE OF NERVE; REQUIRING SHORTENING OF BONE OF EXTREMITY (LIST SEPARATELY IN ADDITION TO CODE FOR NERVE SUTURE)					
632	64885	NERVE GRAFT (INCLUDES OBTAINING GRAFT), HEAD OR NECK; UP TO 4 CM IN LENGTH					

(See Addendum D. for Payment of Medical Visits)

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[2] Copyright 1994 American Dental Association. All rights reserved.

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
632	64886	NERVE GRAFT (INCLUDES OBTAINING GRAFT), HEAD OR NECK; MORE THAN 4 CM LENGTH					
632	64890	NERVE GRAFT (INCLUDES OBTAINING GRAFT), SINGLE STRAND, HAND OR FOOT; UP TO 4 CM LENGTH					
632	64891	NERVE GRAFT (INCLUDES OBTAINING GRAFT), SINGLE STRAND, HAND OR FOOT; MORE THAN 4 CM LENGTH					
632	64892	NERVE GRAFT (INCLUDES OBTAINING GRAFT), SINGLE STRAND, ARM OR LEG; UP TO 4 CM LENGTH					
632	64893	NERVE GRAFT (INCLUDES OBTAINING GRAFT), SINGLE STRAND, ARM OR LEG; MORE THAN 4 CM LENGTH					
632	64895	NERVE GRAFT (INCLUDES OBTAINING GRAFT), MULTIPLE STRANDS (CABLE), HAND OR FOOT; UP TO 4 CM LENGTH					
632	64896	NERVE GRAFT (INCLUDES OBTAINING GRAFT), MULTIPLE STRANDS (CABLE), HAND OR FOOT; MORE THAN 4 CM LENGTH					
632	64897	NERVE GRAFT (INCLUDES OBTAINING GRAFT), MULTIPLE STRANDS (CABLE), ARM OR LEG; UP TO 4 CM LENGTH					
632	64898	NERVE GRAFT (INCLUDES OBTAINING GRAFT), MULTIPLE STRANDS (CABLE), ARM OR LEG; MORE THAN 4 CM LENGTH					
632	64901	NERVE GRAFT, EACH ADDITIONAL NERVE; SINGLE STRAND					
632	64902	NERVE GRAFT, EACH ADDITIONAL NERVE; MULTIPLE STRANDS (CABLE)					
632	64905	NERVE PEDICLE TRANSFER; FIRST STAGE					
632	64907	NERVE PEDICLE TRANSFER; SECOND STAGE					
648	Laser Retinal Procedures		T	3.94	$199.64	$95.15	$39.93
648	67105	REPAIR OF RETINAL DETACHMENT, ONE OR MORE SESSIONS; PHOTOCOAGULATION, WITH OR WITHOUT DRAINAGE OF SUBRETINAL FLUID					
648	67145	PROPHYLAXIS OF RETINAL DETACHMENT (EG, RETINAL BREAK, LATTICE DEGENERATION) WITHOUT DRAINAGE, ONE OR MORE SESSIONS; PHOTOCOAGULATION (LASER OR XENON ARC)					
648	67210	DESTRUCTION OF LOCALIZED LESION OF RETINA (EG, MACULOPATHY, CHOROIDOPATHY, SMALL TUMORS), ONE OR MORE SESSIONS; PHOTOCOAGULATION (LASER OR XENON ARC)					
648	67228	DESTRUCTION OF EXTENSIVE OR PROGRESSIVE RETINOPATHY (EG, DIABETIC RETINOPATHY), ONE OR MORE SESSIONS; PHOTOCOAGULATION (LASER OR XENON ARC)					
649	Laser Eye Procedures except Retinal		T	4.44	$224.97	$111.64	$44.99
649	65855	TRABECULOPLASTY BY LASER SURGERY, ONE OR MORE SESSIONS (DEFINED TREATMENT SERIES)					
649	65860	SEVERING ADHESIONS OF ANTERIOR SEGMENT, LASER TECHNIQUE (SEPARATE PROCEDURE)					
649	66761	IRIDOTOMY/IRIDECTOMY BY LASER SURGERY (EG, FOR GLAUCOMA) (ONE OR MORE SESSIONS)					
649	66762	IRIDOPLASTY BY PHOTOCOAGULATION (ONE OR MORE SESSIONS) (EG, FOR IMPROVEMENT OF VISION, FOR WIDENING OF ANTERIOR CHAMBER ANGLE)					
649	66770	DESTRUCTION OF CYST OR LESION IRIS OR CILIARY BODY (NONEXCISIONAL PROCEDURE)					
649	66821	DISCISSION OF SECONDARY MEMBRANOUS CATARACT (OPACIFIED POSTERIOR LENS CAPSULE AND/OR ANTERIOR HYALOID); LASER SURGERY (EG, YAG LASER) (ONE OR MORE STAGES)					
649	66999	UNLISTED PROCEDURE, ANTERIOR SEGMENT OF EYE					
649	67031	SEVERING OF VITREOUS STRANDS, VITREOUS FACE ADHESIONS, SHEETS, MEMBRANES OR OPACITIES, LASER SURGERY (ONE OR MORE STAGES)					
649	67299	UNLISTED PROCEDURE, POSTERIOR SEGMENT					
651	Level I Anterior Segment Eye Procedures		T	7.24	$366.85	$174.7	$73.37
651	65272	REPAIR OF LACERATION; CONJUNCTIVA, BY MOBILIZATION AND REARRANGEMENT, WITHOUT HOSPITALIZATION					
651	65275	REPAIR OF LACERATION; CORNEA, NONPERFORATING, WITH OR WITHOUT REMOVAL FOREIGN BODY					
651	65286	REPAIR OF LACERATION; APPLICATION OF TISSUE GLUE, WOUNDS OF CORNEA AND/OR SCLERA					
651	65420	EXCISION OR TRANSPOSITION OF PTERYGIUM; WITHOUT GRAFT					
651	65436	REMOVAL OF CORNEAL EPITHELIUM; WITH APPLICATION OF CHELATING AGENT (EG, EDTA)					
651	65450	DESTRUCTION OF LESION OF CORNEA BY CRYOTHERAPY, PHOTOCOAGULATION OR THERMOCAUTERIZATION					
651	65772	CORNEAL RELAXING INCISION FOR CORRECTION OF SURGICALLY INDUCED ASTIGMATISM					
651	65810	PARACENTESIS OF ANTERIOR CHAMBER OF EYE (SEPARATE PROCEDURE); WITH REMOVAL OF VITREOUS AND/OR DISCISSION OF ANTERIOR HYALOID MEMBRANE, WITH OR WITHOUT AIR INJECTION					
651	65815	PARACENTESIS OF ANTERIOR CHAMBER OF EYE (SEPARATE PROCEDURE); WITH REMOVAL OF BLOOD, WITH OR WITHOUT IRRIGATION AND/OR AIR INJECTION					
651	65820	GONIOTOMY					
651	66130	EXCISION OF LESION, SCLERA					
651	66500	IRIDOTOMY BY STAB INCISION (SEPARATE PROCEDURE); EXCEPT TRANSFIXION					
651	66505	IRIDOTOMY BY STAB INCISION (SEPARATE PROCEDURE); WITH TRANSFIXION AS FOR IRIS BOMBE					
651	66600	IRIDECTOMY, WITH CORNEOSCLERAL OR CORNEAL SECTION; FOR REMOVAL OF LESION					
651	66625	IRIDECTOMY, WITH CORNEOSCLERAL OR CORNEAL SECTION; PERIPHERAL FOR GLAUCOMA (SEPARATE PROCEDURE)					
651	66630	IRIDECTOMY, WITH CORNEOSCLERAL OR CORNEAL SECTION; SECTOR FOR GLAUCOMA (SEPARATE PROCEDURE)					
651	66700	CILIARY BODY DESTRUCTION; DIATHERMY					
651	66710	CILIARY BODY DESTRUCTION; CYCLOPHOTOCOAGULATION					
651	66720	CILIARY BODY DESTRUCTION; CRYOTHERAPY					
651	66820	DISCISSION OF SECONDARY MEMBRANOUS CATARACT (OPACIFIED POSTERIOR LENS CAPSULE AND/OR ANTERIOR HYALOID); STAB INCISION TECHNIQUE (ZIEGLER OR WHEELER KNIFE)					
651	66825	REPOSITIONING OF INTRAOCULAR LENS PROSTHESIS, REQUIRING AN INCISION (SEPARATE PROCEDURE)					
652	Level II Anterior Segment Eye Procedures		T	16.48	$835.03	$433.69	$167.01
652	65235	REMOVAL OF FOREIGN BODY, INTRAOCULAR; FROM ANTERIOR CHAMBER OR LENS					
652	65280	REPAIR OF LACERATION; CORNEA AND/OR SCLERA, PERFORATING, NOT INVOLVING UVEAL TISSUE					
652	65285	REPAIR OF LACERATION; CORNEA AND/OR SCLERA, PERFORATING, WITH REPOSITION OR RESECTION OF UVEAL TISSUE					
652	65400	EXCISION OF LESION, CORNEA (KERATECTOMY, LAMELLAR, PARTIAL), EXCEPT PTERYGIUM					
652	65426	EXCISION OR TRANSPOSITION OF PTERYGIUM; WITH GRAFT					
652	65770	KERATOPROSTHESIS					
652	65775	CORNEAL WEDGE RESECTION FOR CORRECTION OF SURGICALLY INDUCED ASTIGMATISM					
652	65850	TRABECULOTOMY AB EXTERNO					
652	65865	SEVERING ADHESIONS OF ANTERIOR SEGMENT OF EYE, INCISIONAL TECHNIQUE (WITH OR WITHOUT INJECTION OF AIR OR LIQUID) (SEPARATE PROCEDURE); GONIOSYNECHIAE					
652	65870	SEVERING ADHESIONS OF ANTERIOR SEGMENT OF EYE, INCISIONAL TECHNIQUE (WITH OR WITHOUT INJECTION OF AIR OR LIQUID) (SEPARATE PROCEDURE); ANTERIOR SYNECHIAE, EXCEPT GONIOSYNECHIAE					

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
652	65875	SEVERING ADHESIONS OF ANTERIOR SEGMENT OF EYE, INCISIONAL TECHNIQUE (WITH OR WITHOUT INJECTION OF AIR OR LIQUID) (SEPARATE PROCEDURE); POSTERIOR SYNECHIAE					
652	65880	SEVERING ADHESIONS OF ANTERIOR SEGMENT OF EYE, INCISIONAL TECHNIQUE (WITH OR WITHOUT INJECTION OF AIR OR LIQUID) (SEPARATE PROCEDURE); CORNEOVITREAL ADHESIONS					
652	65900	REMOVAL OF EPITHELIAL DOWNGROWTH, ANTERIOR CHAMBER EYE					
652	65920	REMOVAL OF IMPLANTED MATERIAL, ANTERIOR SEGMENT EYE					
652	65930	REMOVAL OF BLOOD CLOT, ANTERIOR SEGMENT EYE					
652	66150	FISTULIZATION OF SCLERA FOR GLAUCOMA; TREPHINATION WITH IRIDECTOMY					
652	66155	FISTULIZATION OF SCLERA FOR GLAUCOMA; THERMOCAUTERIZATION WITH IRIDECTOMY					
652	66160	FISTULIZATION OF SCLERA FOR GLAUCOMA; SCLERECTOMY WITH PUNCH OR SCISSORS, WITH IRIDECTOMY					
652	66165	FISTULIZATION OF SCLERA FOR GLAUCOMA; IRIDENCLEISIS OR IRIDOTASIS					
652	66170	FISTULIZATION OF SCLERA FOR GLAUCOMA; TRABECULECTOMY AB EXTERNO IN ABSENCE OF PREVIOUS SURGERY					
652	66172	FISTULIZATION OF SCLERA FOR GLAUCOMA; TRABECULECTOMY AB EXTERNO WITH SCARRING FROM PREVIOUS OCULAR SURGERY OR TRAUMA (INCLUDES INJECTION OF ANTIFIBROTIC AGENTS)					
652	66180	AQUEOUS SHUNT TO EXTRAOCULAR RESERVOIR (EG, MOLTENO, SCHOCKET, DENVER-KRUPIN)					
652	66185	REVISION OF AQUEOUS SHUNT TO EXTRAOCULAR RESERVOIR					
652	66225	REPAIR OF SCLERAL STAPHYLOMA; WITH GRAFT					
652	66250	REVISION OR REPAIR OF OPERATIVE WOUND OF ANTERIOR SEGMENT, ANY TYPE, EARLY OR LATE, MAJOR OR MINOR PROCEDURE					
652	66605	IRIDECTOMY, WITH CORNEOSCLERAL OR CORNEAL SECTION; WITH CYCLECTOMY					
652	66635	IRIDECTOMY, WITH CORNEOSCLERAL OR CORNEAL SECTION; OPTICAL (SEPARATE PROCEDURE)					
652	66680	REPAIR OF IRIS, CILIARY BODY (AS FOR IRIDODIALYSIS)					
652	66682	SUTURE OF IRIS, CILIARY BODY (SEPARATE PROCEDURE) WITH RETRIEVAL OF SUTURE THROUGH SMALL INCISION (EG, MCCANNEL SUTURE)					
652	66740	CILIARY BODY DESTRUCTION; CYCLODIALYSIS					
652	66830	REMOVAL OF SECONDARY MEMBRANOUS CATARACT (OPACIFIED POSTERIOR LENS CAPSULE AND/OR ANTERIOR HYALOID) WITH CORNEO-SCLERAL SECTION, WITH OR WITHOUT IRIDECTOMY (IRIDOCAPSULOTOMY, IRIDOCAPSULECTOMY)					
652	68130	EXCISION OF LESION, CONJUNCTIVA; WITH ADJACENT SCLERA					
652	68330	REPAIR OF SYMBLEPHARON; CONJUNCTIVOPLASTY, WITHOUT GRAFT					
652	68360	CONJUNCTIVAL FLAP; BRIDGE OR PARTIAL (SEPARATE PROCEDURE)					
652	68362	CONJUNCTIVAL FLAP; TOTAL (SUCH AS GUNDERSON THIN FLAP OR PURSE STRING FLAP)					
667	Cataract Procedures		T	15.33	$776.40	$521.72	$155.28
667	66840	REMOVAL OF LENS MATERIAL; ASPIRATION TECHNIQUE, ONE OR MORE STAGES					
667	66850	REMOVAL OF LENS MATERIAL; PHACOFRAGMENTATION TECHNIQUE (MECHANICAL OR ULTRASONIC) (EG, PHACOEMULSIFICATION), WITH ASPIRATION					
667	66852	REMOVAL OF LENS MATERIAL; PARS PLANA APPROACH, WITH OR WITHOUT VITRECTOMY					
667	66920	REMOVAL OF LENS MATERIAL; INTRACAPSULAR					
667	66930	REMOVAL OF LENS MATERIAL; INTRACAPSULAR, FOR DISLOCATED LENS					
667	66940	REMOVAL OF LENS MATERIAL; EXTRACAPSULAR (OTHER THAN 66840, 66850, 66852)					
668	Cataract Procedures with IOL Insert		T	19.28	$976.91	$530.87	$195.38
668	66983	INTRACAPSULAR CATARACT EXTRACTION WITH INSERTION OF INTRAOCULAR LENS PROSTHESIS (ONE STAGE PROCEDURE)					
668	66984	EXTRACAPSULAR CATARACT REMOVAL WITH INSERTION OF INTRAOCULAR LENS PROSTHESIS (ONE STAGE PROCEDURE), MANUAL OR MECHANICAL TECHNIQUE (EG, IRRIGATION AND ASPIRATION OR PHACOEMULSIFICATION)					
668	66985	INSERTION OF INTRAOCULAR LENS PROSTHESIS (SECONDARY IMPLANT), NOT ASSOCIATED WITH CONCURRENT CATARACT REMOVAL					
668	66986	EXCHANGE OF INTRAOCULAR LENS					
670	Corneal Transplant		T	29.23	$1,481.07	$847.5	$296.21
670	65710	KERATOPLASTY (CORNEAL TRANSPLANT); LAMELLAR					
670	65730	KERATOPLASTY (CORNEAL TRANSPLANT); PENETRATING (EXCEPT IN APHAKIA)					
670	65750	KERATOPLASTY (CORNEAL TRANSPLANT); PENETRATING (IN APHAKIA)					
670	65755	KERATOPLASTY (CORNEAL TRANSPLANT); PENETRATING (IN PSEUDOPHAKIA)					
676	Posterior Segment Eye Procedures		T	6.3	$319.22	$140.35	$63.84
676	65260	REMOVAL OF FOREIGN BODY, INTRAOCULAR; FROM POSTERIOR SEGMENT, MAGNETIC EXTRACTION, ANTERIOR OR POSTERIOR ROUTE					
676	65265	REMOVAL OF FOREIGN BODY, INTRAOCULAR; FROM POSTERIOR SEGMENT, NONMAGNETIC EXTRACTION					
676	66220	REPAIR OF SCLERAL STAPHYLOMA; WITHOUT GRAFT					
676	67005	REMOVAL OF VITREOUS, ANTERIOR APPROACH (OPEN SKY TECHNIQUE OR LIMBAL INCISION); PARTIAL REMOVAL					
676	67010	REMOVAL OF VITREOUS, ANTERIOR APPROACH (OPEN SKY TECHNIQUE OR LIMBAL INCISION); SUBTOTAL REMOVAL WITH MECHANICAL VITRECTOMY					
676	67015	ASPIRATION OR RELEASE OF VITREOUS, SUBRETINAL OR CHOROIDAL FLUID, PARS PLANA APPROACH (POSTERIOR SCLEROTOMY)					
676	67030	DISCISSION OF VITREOUS STRANDS (WITHOUT REMOVAL), PARS PLANA APPROACH					
676	67101	REPAIR OF RETINAL DETACHMENT, ONE OR MORE SESSIONS; CRYOTHERAPY OR DIATHERMY, WITH OR WITHOUT DRAINAGE OF SUBRETINAL FLUID					
676	67110	REPAIR OF RETINAL DETACHMENT; BY INJECTION OF AIR OR OTHER GAS (EG, PNEUMATIC RETINOPEXY)					
676	67115	RELEASE OF ENCIRCLING MATERIAL (POSTERIOR SEGMENT)					
676	67120	REMOVAL OF IMPLANTED MATERIAL, POSTERIOR SEGMENT; EXTRAOCULAR					
676	67121	REMOVAL OF IMPLANTED MATERIAL, POSTERIOR SEGMENT; INTRAOCULAR					
676	67141	PROPHYLAXIS OF RETINAL DETACHMENT (EG, RETINAL BREAK, LATTICE DEGENERATION) WITHOUT DRAINAGE, ONE OR MORE SESSIONS; CRYOTHERAPY, DIATHERMY					
676	67208	DESTRUCTION OF LOCALIZED LESION OF RETINA (EG, MACULOPATHY, CHOROIDOPATHY, SMALL TUMORS), ONE OR MORE SESSIONS; CRYOTHERAPY, DIATHERMY					
676	67218	DESTRUCTION OF LOCALIZED LESION OF RETINA (EG, MACULOPATHY, CHOROIDOPATHY, SMALL TUMORS), ONE OR MORE SESSIONS; RADIATION BY IMPLANTATION OF SOURCE (INCLUDES REMOVAL OF SOURCE)					

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
676	67227	DESTRUCTION OF EXTENSIVE OR PROGRESSIVE RETINOPATHY (EG, DIABETIC RETINOPATHY), ONE OR MORE SESSIONS; CRYOTHERAPY, DIATHERMY					
676	92018	OPHTHALMOLOGICAL EXAMINATION AND EVALUATION, UNDER GENERAL ANESTHESIA, WITH OR WITHOUT MANIPULATION OF GLOBE FOR PASSIVE RANGE OF MOTION OR OTHER MANIPULATION TO FACILITATE DIAGNOSTIC EXAMINATION; COMPLETE					
676	92019	OPHTHALMOLOGICAL EXAMINATION AND EVALUATION, UNDER GENERAL ANESTHESIA, WITH OR WITHOUT MANIPULATION OF GLOBE FOR PASSIVE RANGE OF MOTION OR OTHER MANIPULATION TO FACILITATE DIAGNOSTIC EXAMINATION; LIMITED					
677	Strabismus/Muscle Procedures		T	16.26	$823.89	$436.63	$164.78
677	65290	REPAIR OF WOUND, EXTRAOCULAR MUSCLE, TENDON AND/OR TENON'S CAPSULE					
677	67311	STRABISMUS SURGERY, RECESSION OR RESECTION PROCEDURE (PATIENT NOT PREVIOUSLY OPERATED ON); ONE HORIZONTAL MUSCLE					
677	67312	STRABISMUS SURGERY, RECESSION OR RESECTION PROCEDURE (PATIENT NOT PREVIOUSLY OPERATED ON); TWO HORIZONTAL MUSCLES					
677	67314	STRABISMUS SURGERY, RECESSION OR RESECTION PROCEDURE (PATIENT NOT PREVIOUSLY OPERATED ON); ONE VERTICAL MUSCLE (EXCLUDING SUPERIOR OBLIQUE)					
677	67316	STRABISMUS SURGERY, RECESSION OR RESECTION PROCEDURE (PATIENT NOT PREVIOUSLY OPERATED ON); TWO OR MORE VERTICAL MUSCLES (EXCLUDING SUPERIOR OBLIQUE)					
677	67318	STRABISMUS SURGERY, ANY PROCEDURE (PATIENT NOT PREVIOUSLY OPERATED ON), SUPERIOR OBLIQUE MUSCLE					
677	67320	TRANSPOSITION PROCEDURE (EG, FOR PARETIC EXTRAOCULAR MUSCLE), ANY EXTRAOCULAR MUSCLE (SPECIFY)					
677	67331	STRABISMUS SURGERY ON PATIENT WITH PREVIOUS EYE SURGERY OR INJURY THAT DID NOT INVOLVE THE EXTRAOCULAR MUSCLES					
677	67332	STRABISMUS SURGERY ON PATIENT WITH SCARRING OF EXTRAOCULAR MUSCLES (EG, PRIOR OCULAR INJURY, STRABISMUS OR RETINAL DETACHMENT SURGERY) OR RESTRICTIVE MYOPATHY (EG, DYSTHYROID OPHTHALMOPATHY)					
677	67334	STRABISMUS SURGERY BY POSTERIOR FIXATION SUTURE TECHNIQUE, WITH OR WITHOUT MUSCLE RECESSION					
677	67335	PLACEMENT OF ADJUSTABLE SUTURE(S) DURING STRABISMUS SURGERY, INCLUDING POSTOPERATIVE ADJUSTMENT(S) OF SUTURE(S) (REPORT IN ADDITION TO CODE FOR SPECIFIC STRABISMUS SURGERY)					
677	67340	STRABISMUS SURGERY INVOLVING EXPLORATION AND/OR REPAIR OF DETACHED EXTRAOCULAR MUSCLE(S)					
677	67343	RELEASE OF EXTENSIVE SCAR TISSUE WITHOUT DETACHING EXTRAOCULAR MUSCLE (SEPARATE PROCEDURE)					
681	Level I Eye Procedures		T	1.67	$84.62	$30.51	$16.92
681	65125	MODIFICATION OF OCULAR IMPLANT WITH PLACEMENT OR REPLACEMENT OF PEGS (EG, DRILLING RECEPTACLE FOR PROSTHESIS APPENDAGE) (SEPARATE PROCEDURE)					
681	65205	REMOVAL OF FOREIGN BODY, EXTERNAL EYE; CONJUNCTIVAL SUPERFICIAL					
681	65210	REMOVAL OF FOREIGN BODY, EXTERNAL EYE; CONJUNCTIVAL EMBEDDED (INCLUDES CONCRETIONS), SUBCONJUNCTIVAL, OR SCLERAL NONPERFORATING					
681	65220	REMOVAL OF FOREIGN BODY, EXTERNAL EYE; CORNEAL, WITHOUT SLIT LAMP					
681	65222	REMOVAL OF FOREIGN BODY, EXTERNAL EYE; CORNEAL, WITH SLIT LAMP					
681	65430	SCRAPING OF CORNEA, DIAGNOSTIC, FOR SMEAR AND/OR CULTURE					
681	65435	REMOVAL OF CORNEAL EPITHELIUM; WITH OR WITHOUT CHEMOCAUTERIZATION (ABRASION, CURETTAGE)					
681	65600	MULTIPLE PUNCTURES OF ANTERIOR CORNEA (EG, FOR CORNEAL EROSION, TATTOO)					
681	67345	CHEMODENERVATION OF EXTRAOCULAR MUSCLE					
681	67500	RETROBULBAR INJECTION; MEDICATION (SEPARATE PROCEDURE, DOES NOT INCLUDE SUPPLY OF MEDICATION)					
681	67505	RETROBULBAR INJECTION; ALCOHOL					
681	67515	INJECTION OF THERAPEUTIC AGENT INTO TENON'S CAPSULE					
681	67599	UNLISTED PROCEDURE, ORBIT					
681	68200	SUBCONJUNCTIVAL INJECTION					
681	68761	CLOSURE OF THE LACRIMAL PUNCTUM; BY PLUG, EACH					
681	68899	UNLISTED PROCEDURE, LACRIMAL SYSTEM					
682	Level II Eye Procedures		T	3.54	$179.37	$81.36	$35.87
682	67028	INTRAVITREAL INJECTION OF A PHARMACOLOGIC AGENT (SEPARATE PROCEDURE)					
682	67700	BLEPHAROTOMY, DRAINAGE OF ABSCESS, EYELID					
682	67710	SEVERING OF TARSORRHAPHY					
682	67800	EXCISION OF CHALAZION; SINGLE					
682	67801	EXCISION OF CHALAZION; MULTIPLE, SAME LID					
682	67805	EXCISION OF CHALAZION; MULTIPLE, DIFFERENT LIDS					
682	67810	BIOPSY OF EYELID					
682	67820	CORRECTION OF TRICHIASIS; EPILATION, BY FORCEPS ONLY					
682	67825	CORRECTION OF TRICHIASIS; EPILATION BY OTHER THAN FORCEPS (EG, BY ELECTROSURGERY, CRYOTHERAPY, LASER SURGERY					
682	67840	EXCISION OF LESION OF EYELID (EXCEPT CHALAZION) WITHOUT CLOSURE OR WITH SIMPLE DIRECT CLOSURE					
682	67850	DESTRUCTION OF LESION OF LID MARGIN (UP TO 1 CM)					
682	67875	TEMPORARY CLOSURE OF EYELIDS BY SUTURE (EG, FROST SUTURE)					
682	67915	REPAIR OF ECTROPION; THERMOCAUTERIZATION					
682	67922	REPAIR OF ENTROPION; THERMOCAUTERIZATION					
682	67930	SUTURE OF RECENT WOUND, EYELID, INVOLVING LID MARGIN, TARSUS, AND/OR PALPEBRAL CONJUNCTIVA DIRECT CLOSURE; PARTIAL THICKNESS					
682	67938	REMOVAL OF EMBEDDED FOREIGN BODY, EYELID					
682	67999	UNLISTED PROCEDURE, EYELIDS					
682	68020	INCISION OF CONJUNCTIVA, DRAINAGE OF CYST					
682	68040	EXPRESSION OF CONJUNCTIVAL FOLLICLES (EG, FOR TRACHOMA)					
682	68400	INCISION, DRAINAGE OF LACRIMAL GLAND					
682	68420	INCISION, DRAINAGE OF LACRIMAL SAC (DACRYOCYSTOTOMY OR DACRYOCYSTOSTOMY)					
682	68440	SNIP INCISION OF LACRIMAL PUNCTUM					
682	68530	REMOVAL OF FOREIGN BODY OR DACRYOLITH, LACRIMAL PASSAGES					
682	68705	CORRECTION OF EVERTED PUNCTUM, CAUTERY					
682	68760	CLOSURE OF THE LACRIMAL PUNCTUM; BY THERMOCAUTERIZATION, LIGATION, OR LASER SURGERY					
682	68801	DILATION OF LACRIMAL PUNCTUM, WITH OR WITHOUT IRRIGATION					

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
682	68840	PROBING OF LACRIMAL CANALICULI, WITH OR WITHOUT IRRIGATION					
683	Level III Eye Procedures		T	10.19	$516.32	$257.87	$103.26
683	65175	REMOVAL OF OCULAR IMPLANT					
683	65410	BIOPSY OF CORNEA					
683	65800	PARACENTESIS OF ANTERIOR CHAMBER OF EYE (SEPARATE PROCEDURE); WITH DIAGNOSTIC ASPIRATION OF AQUEOUS					
683	65805	PARACENTESIS OF ANTERIOR CHAMBER OF EYE (SEPARATE PROCEDURE); WITH THERAPEUTIC RELEASE OF AQUEOUS					
683	66020	INJECTION, ANTERIOR CHAMBER (SEPARATE PROCEDURE); AIR OR LIQUID					
683	66030	INJECTION, ANTERIOR CHAMBER (SEPARATE PROCEDURE); MEDICATION					
683	67025	INJECTION OF VITREOUS SUBSTITUTE, PARS PLANA OR LIMBAL APPROACH, (FLUID-GAS EXCHANGE), WITH OR WITHOUT ASPIRATION (SEPARATE PROCEDURE)					
683	67715	CANTHOTOMY (SEPARATE PROCEDURE)					
683	67830	CORRECTION OF TRICHIASIS; INCISION OF LID MARGIN					
683	67880	CONSTRUCTION OF INTERMARGINAL ADHESIONS, MEDIAN TARSORRHAPHY, OR CANTHORRHAPHY					
683	67935	SUTURE OF RECENT WOUND, EYELID, INVOLVING LID MARGIN, TARSUS, AND/OR PALPEBRAL CONJUNCTIVA DIRECT CLOSURE; FULL THICKNESS					
683	68510	BIOPSY OF LACRIMAL GLAND					
683	68525	BIOPSY OF LACRIMAL SAC					
683	68810	PROBING OF NASOLACRIMAL DUCT, WITH OR WITHOUT IRRIGATION;					
684	Level IV Eye Procedures		T	13.48	$683.02	$348.94	$136.6
684	65091	EVISCERATION OF OCULAR CONTENTS; WITHOUT IMPLANT					
684	65093	EVISCERATION OF OCULAR CONTENTS; WITH IMPLANT					
684	65101	ENUCLEATION OF EYE; WITHOUT IMPLANT					
684	65103	ENUCLEATION OF EYE; WITH IMPLANT, MUSCLES NOT ATTACHED TO IMPLANT					
684	65105	ENUCLEATION OF EYE; WITH IMPLANT, MUSCLES ATTACHED TO IMPLANT					
684	65130	INSERTION OF OCULAR IMPLANT SECONDARY; AFTER EVISCERATION, IN SCLERAL SHELL					
684	65135	INSERTION OF OCULAR IMPLANT SECONDARY; AFTER ENUCLEATION, MUSCLES NOT ATTACHED TO IMPLANT					
684	65140	INSERTION OF OCULAR IMPLANT SECONDARY; AFTER ENUCLEATION, MUSCLES ATTACHED TO IMPLANT					
684	65150	REINSERTION OF OCULAR IMPLANT; WITH OR WITHOUT CONJUNCTIVAL GRAFT					
684	65155	REINSERTION OF OCULAR IMPLANT; WITH USE OF FOREIGN MATERIAL FOR REINFORCEMENT AND/OR ATTACHMENT OF MUSCLES TO IMPLANT					
684	67250	SCLERAL REINFORCEMENT (SEPARATE PROCEDURE); WITHOUT GRAFT					
684	67255	SCLERAL REINFORCEMENT (SEPARATE PROCEDURE); WITH GRAFT					
684	67400	ORBITOTOMY WITHOUT BONE FLAP (FRONTAL OR TRANSCONJUNCTIVAL APPROACH); FOR EXPLORATION, WITH OR WITHOUT BIOPSY					
684	67405	ORBITOTOMY WITHOUT BONE FLAP (FRONTAL OR TRANSCONJUNCTIVAL APPROACH); WITH DRAINAGE ONLY					
684	67412	ORBITOTOMY WITHOUT BONE FLAP (FRONTAL OR TRANSCONJUNCTIVAL APPROACH); WITH REMOVAL OF LESION					
684	67413	ORBITOTOMY WITHOUT BONE FLAP (FRONTAL OR TRANSCONJUNCTIVAL APPROACH); WITH REMOVAL OF FOREIGN BODY					
684	67550	ORBITAL IMPLANT (IMPLANT OUTSIDE MUSCLE CONE); INSERTION					
684	67560	ORBITAL IMPLANT (IMPLANT OUTSIDE MUSCLE CONE); REMOVAL OR REVISION					
684	67808	EXCISION OF CHALAZION; UNDER GENERAL ANESTHESIA AND/OR REQUIRING HOSPITALIZATION, SINGLE OR MULTIPLE					
684	67835	CORRECTION OF TRICHIASIS; INCISION OF LID MARGIN, WITH FREE MUCOUS MEMBRANE GRAFT					
684	67882	CONSTRUCTION OF INTERMARGINAL ADHESIONS, MEDIAN TARSORRHAPHY, OR CANTHORRHAPHY; WITH TRANSPOSITION OF TARSAL PLATE					
684	67900	REPAIR OF BROW PTOSIS (SUPRACILIARY, MID-FOREHEAD OR CORONAL APPROACH)					
684	67901	REPAIR OF BLEPHAROPTOSIS; FRONTALIS MUSCLE TECHNIQUE WITH SUTURE OR OTHER MATERIAL					
684	67902	REPAIR OF BLEPHAROPTOSIS; FRONTALIS MUSCLE TECHNIQUE WITH FASCIAL SLING (INCLUDES OBTAINING FASCIA)					
684	67903	REPAIR OF BLEPHAROPTOSIS; (TARSO)LEVATOR RESECTION OR ADVANCEMENT, INTERNAL APPROACH					
684	67904	REPAIR OF BLEPHAROPTOSIS; (TARSO)LEVATOR RESECTION OR ADVANCEMENT, EXTERNAL APPROACH					
684	67906	REPAIR OF BLEPHAROPTOSIS; SUPERIOR RECTUS TECHNIQUE WITH FASCIAL SLING (INCLUDES OBTAINING FASCIA)					
684	67908	REPAIR OF BLEPHAROPTOSIS; CONJUNCTIVO-TARSO-MULLER'S MUSCLE-LEVATOR RESECTION (EG, FASANELLA-SERVAT TYPE)					
684	67909	REDUCTION OF OVERCORRECTION OF PTOSIS					
684	67911	CORRECTION OF LID RETRACTION					
684	67914	REPAIR OF ECTROPION; SUTURE					
684	67916	REPAIR OF ECTROPION; BLEPHAROPLASTY, EXCISION TARSAL WEDGE					
684	67917	REPAIR OF ECTROPION; BLEPHAROPLASTY, EXTENSIVE (EG, KUHNT-SZYMANOWSKI OR TARSAL STRIP OPERATIONS)					
684	67921	REPAIR OF ENTROPION; SUTURE					
684	67923	REPAIR OF ENTROPION; BLEPHAROPLASTY, EXCISION TARSAL WEDGE					
684	67924	REPAIR OF ENTROPION; BLEPHAROPLASTY, EXTENSIVE (EG, WHEELER OPERATION)					
684	67950	CANTHOPLASTY (RECONSTRUCTION OF CANTHUS)					
684	67961	EXCISION AND REPAIR OF EYELID, INVOLVING LID MARGIN, TARSUS, CONJUNCTIVA, CANTHUS, OR FULL THICKNESS, MAY INCLUDE PREPARATION FOR SKIN GRAFT OR PEDICLE FLAP WITH ADJACENT TISSUE TRANSFER OR REARRANGEMENT; UP TO ONE-FOURTH OF LID MARGIN					
684	67966	EXCISION AND REPAIR OF EYELID, INVOLVING LID MARGIN, TARSUS, CONJUNCTIVA, CANTHUS, OR FULL THICKNESS, MAY INCLUDE PREPARATION FOR SKIN GRAFT OR PEDICLE FLAP WITH ADJACENT TISSUE TRANSFER OR REARRANGEMENT; OVER ONE-FOURTH OF LID MARGIN					
684	67971	RECONSTRUCTION OF EYELID, FULL THICKNESS BY TRANSFER OF TARSOCONJUNCTIVAL FLAP FROM OPPOSING EYELID; UP TO TWO-THIRDS OF EYELID, ONE STAGE OR FIRST STAGE					
684	67973	RECONSTRUCTION OF EYELID, FULL THICKNESS BY TRANSFER OF TARSOCONJUNCTIVAL FLAP FROM OPPOSING EYELID; TOTAL EYELID, LOWER, ONE STAGE OR FIRST STAGE					
684	67974	RECONSTRUCTION OF EYELID, FULL THICKNESS BY TRANSFER OF TARSOCONJUNCTIVAL FLAP FROM OPPOSING EYELID; TOTAL EYELID, UPPER, ONE STAGE OR FIRST STAGE					
684	67975	RECONSTRUCTION OF EYELID, FULL THICKNESS BY TRANSFER OF TARSOCONJUNCTIVAL FLAP FROM OPPOSING EYELID; SECOND STAGE					
684	68320	CONJUNCTIVOPLASTY; WITH CONJUNCTIVAL GRAFT OR EXTENSIVE REARRANGEMENT					

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
684	68325	CONJUNCTIVOPLASTY; WITH BUCCAL MUCOUS MEMBRANE GRAFT (INCLUDES OBTAINING GRAFT)					
684	68326	CONJUNCTIVOPLASTY, RECONSTRUCTION CUL-DE-SAC; WITH CONJUNCTIVAL GRAFT OR EXTENSIVE REARRANGEMENT					
684	68328	CONJUNCTIVOPLASTY, RECONSTRUCTION CUL-DE-SAC; WITH BUCCAL MUCOUS MEMBRANE GRAFT (INCLUDES OBTAINING GRAFT)					
684	68335	REPAIR OF SYMBLEPHARON; WITH FREE GRAFT CONJUNCTIVA OR BUCCAL MUCOUS MEMBRANE (INCLUDES OBTAINING GRAFT)					
684	68340	REPAIR OF SYMBLEPHARON; DIVISION OF SYMBLEPHARON, WITH OR WITHOUT INSERTION OF CONFORMER OR CONTACT LENS					
684	68500	EXCISION OF LACRIMAL GLAND (DACRYOADENECTOMY), EXCEPT FOR TUMOR; TOTAL					
684	68505	EXCISION OF LACRIMAL GLAND (DACRYOADENECTOMY), EXCEPT FOR TUMOR; PARTIAL					
684	68520	EXCISION OF LACRIMAL SAC (DACRYOCYSTECTOMY)					
684	68540	EXCISION OF LACRIMAL GLAND TUMOR; FRONTAL APPROACH					
684	68550	EXCISION OF LACRIMAL GLAND TUMOR; INVOLVING OSTEOTOMY					
684	68700	PLASTIC REPAIR OF CANALICULI					
684	68720	DACRYOCYSTORHINOSTOMY (FISTULIZATION OF LACRIMAL SAC TO NASAL CAVITY)					
684	68745	CONJUNCTIVORHINOSTOMY (FISTULIZATION OF CONJUNCTIVA TO NASAL CAVITY); WITHOUT TUBE					
684	68750	CONJUNCTIVORHINOSTOMY (FISTULIZATION OF CONJUNCTIVA TO NASAL CAVITY); WITH INSERTION OF TUBE OR STENT					
684	68770	CLOSURE OF LACRIMAL FISTULA (SEPARATE PROCEDURE)					
684	68811	PROBING OF NASOLACRIMAL DUCT, WITH OR WITHOUT IRRIGATION; REQUIRING GENERAL ANESTHESIA					
684	68815	PROBING OF NASOLACRIMAL DUCT, WITH OR WITHOUT IRRIGATION; WITH INSERTION OF TUBE OR STENT					
690	Vitrectomy		T	30.54	$1,547.45	$852.02	$309.49
690	67027	IMPLANTATION OR REPLACEMENT OF INTRAVITREAL DRUG DELIVERY SYSTEM (EG, GANCICLOVIR IMPLANT), INCLUDES CONCOMITANT REMOVAL OF VITREOUS					
690	67036	VITRECTOMY, MECHANICAL, PARS PLANA APPROACH;					
690	67038	VITRECTOMY, MECHANICAL, PARS PLANA APPROACH; WITH EPIRETINAL MEMBRANE STRIPPING					
690	67039	VITRECTOMY, MECHANICAL, PARS PLANA APPROACH; WITH FOCAL ENDOLASER PHOTOCOAGULATION					
690	67040	VITRECTOMY, MECHANICAL, PARS PLANA APPROACH; WITH ENDOLASER PANRETINAL PHOTOCOAGULATION					
690	67107	REPAIR OF RETINAL DETACHMENT; SCLERAL BUCKLING (SUCH AS LAMELLAR SCLERAL DISSECTION, IMBRICATION OR ENCIRCLING PROCEDURE), WITH OR WITHOUT IMPLANT, WITH OR WITHOUT CRYOTHERAPY, PHOTOCOAGULATION, AND DRAINAGE OF SUBRETINAL FLUID					
690	67108	REPAIR OF RETINAL DETACHMENT; WITH VITRECTOMY, ANY METHOD, WITH OR WITHOUT AIR OR GAS TAMPONADE, FOCAL ENDOLASER PHOTOCOAGULATION, CRYOTHERAPY, DRAINAGE OF SUBRETINAL FLUID, SCLERAL BUCKLING, AND/OR REMOVAL OF LENS BY SAME TECHNIQUE					
690	67112	REPAIR OF RETINAL DETACHMENT; BY SCLERAL BUCKLING OR VITRECTOMY, ON PATIENT HAVING PREVIOUS IPSILATERAL RETINAL DETACHMENT REPAIR(S) USING SCLERAL BUCKLING OR VITRECTOMY TECHNIQUES					
700	Plain Film		X	0.78	$39.52	$22.37	$7.90
700	70030	RADIOLOGIC EXAMINATION, EYE, FOR DETECTION OF FOREIGN BODY					
700	70100	RADIOLOGIC EXAMINATION, MANDIBLE; PARTIAL, LESS THAN FOUR VIEWS					
700	70110	RADIOLOGIC EXAMINATION, MANDIBLE; COMPLETE, MINIMUM OF FOUR VIEWS					
700	70120	RADIOLOGIC EXAMINATION, MASTOIDS; LESS THAN THREE VIEWS PER SIDE					
700	70130	RADIOLOGIC EXAMINATION, MASTOIDS; COMPLETE, MINIMUM OF THREE VIEWS PER SIDE					
700	70134	RADIOLOGIC EXAMINATION, INTERNAL AUDITORY MEATI, COMPLETE					
700	70140	RADIOLOGIC EXAMINATION, FACIAL BONES; LESS THAN THREE VIEWS					
700	70150	RADIOLOGIC EXAMINATION, FACIAL BONES; COMPLETE, MINIMUM OF THREE VIEWS					
700	70160	RADIOLOGIC EXAMINATION, NASAL BONES, COMPLETE, MINIMUM OF THREE VIEWS					
700	70190	RADIOLOGIC EXAMINATION; OPTIC FORAMINA					
700	70200	RADIOLOGIC EXAMINATION; ORBITS, COMPLETE, MINIMUM OF FOUR VIEWS					
700	70210	RADIOLOGIC EXAMINATION, SINUSES, PARANASAL, LESS THAN THREE VIEWS					
700	70220	RADIOLOGIC EXAMINATION, SINUSES, PARANASAL, COMPLETE, MINIMUM OF THREE VIEWS					
700	70240	RADIOLOGIC EXAMINATION, SELLA TURCICA					
700	70250	RADIOLOGIC EXAMINATION, SKULL; LESS THAN FOUR VIEWS, WITH OR WITHOUT STEREO					
700	70260	RADIOLOGIC EXAMINATION, SKULL; COMPLETE, MINIMUM OF FOUR VIEWS, WITH OR WITHOUT STEREO					
700	70300	RADIOLOGIC EXAMINATION, TEETH; SINGLE VIEW					
700	70310	RADIOLOGIC EXAMINATION, TEETH; PARTIAL EXAMINATION, LESS THAN FULL MOUTH					
700	70320	RADIOLOGIC EXAMINATION, TEETH; COMPLETE, FULL MOUTH					
700	70328	RADIOLOGIC EXAMINATION, TEMPOROMANDIBULAR JOINT, OPEN AND CLOSED MOUTH; UNILATERAL					
700	70330	RADIOLOGIC EXAMINATION, TEMPOROMANDIBULAR JOINT, OPEN AND CLOSED MOUTH; BILATERAL					
700	70350	CEPHALOGRAM, ORTHODONTIC					
700	70355	ORTHOPANTOGRAM					
700	70360	RADIOLOGIC EXAMINATION; NECK, SOFT TISSUE					
700	70380	RADIOLOGIC EXAMINATION, SALIVARY GLAND FOR CALCULUS					
700	71010	RADIOLOGIC EXAMINATION, CHEST; SINGLE VIEW, FRONTAL					
700	71015	RADIOLOGIC EXAMINATION, CHEST; STEREO, FRONTAL					
700	71020	RADIOLOGIC EXAMINATION, CHEST, TWO VIEWS, FRONTAL AND LATERAL;					
700	71021	RADIOLOGIC EXAMINATION, CHEST, TWO VIEWS, FRONTAL AND LATERAL; WITH APICAL LORDOTIC PROCEDURE					
700	71022	RADIOLOGIC EXAMINATION, CHEST, TWO VIEWS, FRONTAL AND LATERAL; WITH OBLIQUE PROJECTIONS					
700	71030	RADIOLOGIC EXAMINATION, CHEST, COMPLETE, MINIMUM OF FOUR VIEWS;					
700	71035	RADIOLOGIC EXAMINATION, CHEST, SPECIAL VIEWS (EG, LATERAL DECUBITUS, BUCKY STUDIES)					
700	71100	RADIOLOGIC EXAMINATION, RIBS, UNILATERAL; TWO VIEWS					
700	71101	RADIOLOGIC EXAMINATION, RIBS, UNILATERAL; INCLUDING POSTEROANTERIOR CHEST, MINIMUM OF THREE VIEWS					
700	71110	RADIOLOGIC EXAMINATION, RIBS, BILATERAL; THREE VIEWS					
700	71111	RADIOLOGIC EXAMINATION, RIBS, BILATERAL; INCLUDING POSTEROANTERIOR CHEST, MINIMUM OF FOUR VIEWS					
700	71120	RADIOLOGIC EXAMINATION; STERNUM, MINIMUM OF TWO VIEWS					
700	71130	RADIOLOGIC EXAMINATION; STERNOCLAVICULAR JOINT OR JOINTS, MINIMUM OF THREE VIEWS					
700	72010	RADIOLOGIC EXAMINATION, SPINE, ENTIRE, SURVEY STUDY, ANTEROPOSTERIOR AND LATERAL					
700	72020	RADIOLOGIC EXAMINATION, SPINE, SINGLE VIEW, SPECIFY LEVEL					
700	72040	RADIOLOGIC EXAMINATION, SPINE, CERVICAL; ANTEROPOSTERIOR AND LATERAL					

(See Addendum D. for Payment of Medical Visits)

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
700	72050	RADIOLOGIC EXAMINATION, SPINE, CERVICAL; MINIMUM OF FOUR VIEWS					
700	72052	RADIOLOGIC EXAMINATION, SPINE, CERVICAL; COMPLETE, INCLUDING OBLIQUE AND FLEXION AND/OR EXTENSION STUDIES					
700	72069	RADIOLOGIC EXAMINATION, SPINE, THORACOLUMBAR, STANDING (SCOLIOSIS)					
700	72070	RADIOLOGIC EXAMINATION, SPINE; THORACIC, ANTEROPOSTERIOR AND LATERAL					
700	72072	RADIOLOGIC EXAMINATION, SPINE; THORACIC, ANTEROPOSTERIOR AND LATERAL, INCLUDING SWIMMER'S VIEW OF THE CERVICOTHORACIC JUNCTION					
700	72074	RADIOLOGIC EXAMINATION, SPINE; THORACIC, COMPLETE, INCLUDING OBLIQUES, MINIMUM OF FOUR VIEWS					
700	72080	RADIOLOGIC EXAMINATION, SPINE; THORACOLUMBAR, ANTEROPOSTERIOR AND LATERAL					
700	72090	RADIOLOGIC EXAMINATION, SPINE; SCOLIOSIS STUDY, INCLUDING SUPINE AND ERECT STUDIES					
700	72100	RADIOLOGIC EXAMINATION, SPINE, LUMBOSACRAL; ANTEROPOSTERIOR AND LATERAL					
700	72110	RADIOLOGIC EXAMINATION, SPINE, LUMBOSACRAL; COMPLETE, WITH OBLIQUE VIEWS					
700	72114	RADIOLOGIC EXAMINATION, SPINE, LUMBOSACRAL; COMPLETE, INCLUDING BENDING VIEWS					
700	72120	RADIOLOGIC EXAMINATION, SPINE, LUMBOSACRAL, BENDING VIEWS ONLY, MINIMUM OF FOUR VIEWS					
700	72170	RADIOLOGIC EXAMINATION, PELVIS; ANTEROPOSTERIOR ONLY					
700	72190	RADIOLOGIC EXAMINATION, PELVIS; COMPLETE, MINIMUM OF THREE VIEWS					
700	72200	RADIOLOGIC EXAMINATION, SACROILIAC JOINTS; LESS THAN THREE VIEWS					
700	72202	RADIOLOGIC EXAMINATION, SACROILIAC JOINTS; THREE OR MORE VIEWS					
700	72220	RADIOLOGIC EXAMINATION, SACRUM AND COCCYX, MINIMUM OF TWO VIEWS					
700	73000	RADIOLOGIC EXAMINATION; CLAVICLE, COMPLETE					
700	73010	RADIOLOGIC EXAMINATION; SCAPULA, COMPLETE					
700	73020	RADIOLOGIC EXAMINATION, SHOULDER; ONE VIEW					
700	73030	RADIOLOGIC EXAMINATION, SHOULDER; COMPLETE, MINIMUM OF TWO VIEWS					
700	73050	RADIOLOGIC EXAMINATION; ACROMIOCLAVICULAR JOINTS, BILATERAL, WITH OR WITHOUT WEIGHTED DISTRACTION					
700	73060	RADIOLOGIC EXAMINATION; HUMERUS, MINIMUM OF TWO VIEWS					
700	73070	RADIOLOGIC EXAMINATION, ELBOW; ANTEROPOSTERIOR AND LATERAL VIEWS					
700	73080	RADIOLOGIC EXAMINATION, ELBOW; COMPLETE, MINIMUM OF THREE VIEWS					
700	73090	RADIOLOGIC EXAMINATION; FOREARM, ANTEROPOSTERIOR AND LATERAL VIEWS					
700	73092	RADIOLOGIC EXAMINATION; UPPER EXTREMITY, INFANT, MINIMUM OF TWO VIEWS					
700	73100	RADIOLOGIC EXAMINATION, WRIST; ANTEROPOSTERIOR AND LATERAL VIEWS					
700	73110	RADIOLOGIC EXAMINATION, WRIST; COMPLETE, MINIMUM OF THREE VIEWS					
700	73120	RADIOLOGIC EXAMINATION, HAND; TWO VIEWS					
700	73130	RADIOLOGIC EXAMINATION, HAND; MINIMUM OF THREE VIEWS					
700	73140	RADIOLOGIC EXAMINATION, FINGER(S), MINIMUM OF TWO VIEWS					
700	73500	RADIOLOGIC EXAMINATION, HIP, UNILATERAL; ONE VIEW					
700	73510	RADIOLOGIC EXAMINATION, HIP, UNILATERAL; COMPLETE, MINIMUM OF TWO VIEWS					
700	73520	RADIOLOGIC EXAMINATION, HIPS, BILATERAL, MINIMUM OF TWO VIEWS OF EACH HIP, INCLUDING ANTEROPOSTERIOR VIEW OF PELVIS					
700	73530	RADIOLOGIC EXAMINATION, HIP, DURING OPERATIVE PROCEDURE					
700	73540	RADIOLOGIC EXAMINATION, PELVIS AND HIPS, INFANT OR CHILD, MINIMUM OF TWO VIEWS					
700	73550	RADIOLOGIC EXAMINATION, FEMUR, ANTEROPOSTERIOR AND LATERAL VIEWS					
700	73560	RADIOLOGIC EXAMINATION, KNEE; ANTEROPOSTERIOR AND LATERAL VIEWS					
700	73562	RADIOLOGIC EXAMINATION, KNEE; ANTEROPOSTERIOR AND LATERAL, WITH OBLIQUE(S), MINIMUM OF THREE VIEWS					
700	73564	RADIOLOGIC EXAMINATION, KNEE; COMPLETE, INCLUDING OBLIQUE(S), AND TUNNEL, AND/OR PATELLAR AND/OR STANDING VIEWS					
700	73565	RADIOLOGIC EXAMINATION, KNEE; BOTH KNEES, STANDING, ANTEROPOSTERIOR					
700	73590	RADIOLOGIC EXAMINATION; TIBIA AND FIBULA, ANTEROPOSTERIOR AND LATERAL VIEWS					
700	73592	RADIOLOGIC EXAMINATION; LOWER EXTREMITY, INFANT, MINIMUM OF TWO VIEWS					
700	73600	RADIOLOGIC EXAMINATION, ANKLE; ANTEROPOSTERIOR AND LATERAL VIEWS					
700	73610	RADIOLOGIC EXAMINATION, ANKLE; COMPLETE, MINIMUM OF THREE VIEWS					
700	73620	RADIOLOGIC EXAMINATION, FOOT; ANTEROPOSTERIOR AND LATERAL VIEWS					
700	73630	RADIOLOGIC EXAMINATION, FOOT; COMPLETE, MINIMUM OF THREE VIEWS					
700	73650	RADIOLOGIC EXAMINATION; CALCANEUS, MINIMUM OF TWO VIEWS					
700	73660	RADIOLOGIC EXAMINATION; TOE(S), MINIMUM OF TWO VIEWS					
700	74000	RADIOLOGIC EXAMINATION, ABDOMEN; SINGLE ANTEROPOSTERIOR VIEW					
700	74010	RADIOLOGIC EXAMINATION, ABDOMEN; ANTEROPOSTERIOR AND ADDITIONAL OBLIQUE AND CONE VIEWS					
700	74020	RADIOLOGIC EXAMINATION, ABDOMEN; COMPLETE, INCLUDING DECUBITUS AND/OR ERECT VIEWS					
700	74022	RADIOLOGIC EXAMINATION, ABDOMEN; COMPLETE ACUTE ABDOMEN SERIES, INCLUDING SUPINE, ERECT, AND/ OR DECUBITUS VIEWS, UPRIGHT PA CHEST					
700	74710	PELVIMETRY, WITH OR WITHOUT PLACENTAL LOCALIZATION					
700	76010	RADIOLOGIC EXAMINATION FROM NOSE TO RECTUM FOR FOREIGN BODY, SINGLE FILM, CHILD					
700	76020	BONE AGE STUDIES					
700	76040	BONE LENGTH STUDIES (ORTHOROENTGENOGRAM, SCANOGRAM)					
700	76061	RADIOLOGIC EXAMINATION, OSSEOUS SURVEY; LIMITED (EG, FOR METASTASES)					
700	76062	RADIOLOGIC EXAMINATION, OSSEOUS SURVEY; COMPLETE (AXIAL AND APPENDICULAR SKELETON)					
700	76065	RADIOLOGIC EXAMINATION, OSSEOUS SURVEY, INFANT					
700	76066	JOINT SURVEY, SINGLE VIEW, ONE OR MORE JOINTS (SPECIFY)					
700	76076	DUAL ENERGY X-RAY ABSORPTIOMETRY (DEXA), BONE DENSITY STUDY, ONE OR MORE SITES; APPENDICULAR SKELETON (PERIPHERAL) (EG, RADIUS, WRIST, HEEL)					
700	76078	RADIOGRAPHIC ABSORPTIOMETRY (PHOTODENSITOMETRY), ONE OR MORE SITES					
700	76098	RADIOLOGICAL EXAMINATION, SURGICAL SPECIMEN					
700	76100	RADIOLOGIC EXAMINATION, SINGLE PLANE BODY SECTION (EG, TOMOGRAPHY), OTHER THAN WITH UROGRAPHY					
700	76120	CINERADIOGRAPHY, EXCEPT WHERE SPECIFICALLY INCLUDED					
700	76125	CINERADIOGRAPHY TO COMPLEMENT ROUTINE EXAMINATION					
700	76150	XERORADIOGRAPHY					
700	76499	UNLISTED DIAGNOSTIC RADIOLOGIC PROCEDURE					
700	77417	THERAPEUTIC RADIOLOGY PORT FILM(S)					
700	78350	BONE DENSITY (BONE MINERAL CONTENT) STUDY, ONE OR MORE SITES; SINGLE PHOTON ABSORPTIOMETRY					

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
706		Miscellaneous Radiological Procedures	X	1.96	$99.31	$57.63	$19.86
706	70170	DACRYOCYSTOGRAPHY, NASOLACRIMAL DUCT, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
706	70373	LARYNGOGRAPHY, CONTRAST, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
706	70390	SIALOGRAPHY, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
706	71040	BRONCHOGRAPHY, UNILATERAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
706	71060	BRONCHOGRAPHY, BILATERAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
706	74190	PERITONEOGRAM (EG, AFTER INJECTION OF AIR OR CONTRAST), RADIOLOGICAL SUPERVISION AND INTERPRETATION					
706	74305	CHOLANGIOGRAPHY AND/OR PANCREATOGRAPHY; POSTOPERATIVE, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
706	74320	CHOLANGIOGRAPHY, PERCUTANEOUS, TRANSHEPATIC, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
706	74328	ENDOSCOPIC CATHETERIZATION OF THE BILIARY DUCTAL SYSTEM, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
706	74329	ENDOSCOPIC CATHETERIZATION OF THE PANCREATIC DUCTAL SYSTEM, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
706	74330	COMBINED ENDOSCOPIC CATHETERIZATION OF THE BILIARY AND PANCREATIC DUCTAL SYSTEMS, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
706	74350	PERCUTANEOUS PLACEMENT OF GASTROSTOMY TUBE, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
706	74355	PERCUTANEOUS PLACEMENT OF ENTEROCLYSIS TUBE, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
706	74470	RADIOLOGIC EXAMINATION, RENAL CYST STUDY, TRANSLUMBAR, CONTRAST VISUALIZATION, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
706	74740	HYSTEROSALPINGOGRAPHY, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
706	74742	TRANSCERVICAL CATHETERIZATION OF FALLOPIAN TUBE, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
706	75801	LYMPHANGIOGRAPHY, EXTREMITY ONLY, UNILATERAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
706	75803	LYMPHANGIOGRAPHY, EXTREMITY ONLY, BILATERAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
706	75805	LYMPHANGIOGRAPHY, PELVIC/ABDOMINAL, UNILATERAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
706	75807	LYMPHANGIOGRAPHY, PELVIC/ABDOMINAL, BILATERAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
706	75809	SHUNTOGRAM FOR INVESTIGATION OF PREVIOUSLY PLACED INDWELLING NONVASCULAR SHUNT (EG, LEVEEN SHUNT, VENTRICULOPERITONEAL SHUNT), RADIOLOGICAL SUPERVISION AND INTERPRETATION					
706	75898	ANGIOGRAM THROUGH EXISTING CATHETER FOR FOLLOW-UP STUDY FOR TRANSCATHETER THERAPY, EMBOLIZATION OR INFUSION					
706	76075	DUAL ENERGY X-RAY ABSORPTIOMETRY (DEXA), BONE DENSITY STUDY, ONE OR MORE SITES; AXIAL SKELETON (EG, HIPS, PELVIS, SPINE)					
706	76080	RADIOLOGIC EXAMINATION, ABSCESS, FISTULA OR SINUS TRACT STUDY, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
706	76086	MAMMARY DUCTOGRAM OR GALACTOGRAM, SINGLE DUCT, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
706	76088	MAMMARY DUCTOGRAM OR GALACTOGRAM, MULTIPLE DUCTS, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
706	76095	STEREOTACTIC LOCALIZATION FOR BREAST BIOPSY, EACH LESION, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
706	76096	PREOPERATIVE PLACEMENT OF NEEDLE LOCALIZATION WIRE, BREAST, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
706	76101	RADIOLOGIC EXAMINATION, COMPLEX MOTION (IE, HYPERCYCLOIDAL) BODY SECTION (EG, MASTOID POLYTOMOGRAPHY), OTHER THAN WITH UROGRAPHY; UNILATERAL					
706	76102	RADIOLOGIC EXAMINATION, COMPLEX MOTION (IE, HYPERCYCLOIDAL) BODY SECTION (EG, MASTOID POLYTOMOGRAPHY), OTHER THAN WITH UROGRAPHY; BILATERAL					
710		Computerized Axial Tomography	S	5.06	$256.39	$176.28	$51.28
710	70450	COMPUTERIZED AXIAL TOMOGRAPHY, HEAD OR BRAIN; WITHOUT CONTRAST MATERIAL					
710	70460	COMPUTERIZED AXIAL TOMOGRAPHY, HEAD OR BRAIN; WITH CONTRAST MATERIAL(S)					
710	70470	COMPUTERIZED AXIAL TOMOGRAPHY, HEAD OR BRAIN; WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS					
710	70480	COMPUTERIZED AXIAL TOMOGRAPHY, ORBIT, SELLA, OR POSTERIOR FOSSA OR OUTER, MIDDLE, OR INNER EAR; WITHOUT CONTRAST MATERIAL					
710	70481	COMPUTERIZED AXIAL TOMOGRAPHY, ORBIT, SELLA, OR POSTERIOR FOSSA OR OUTER, MIDDLE, OR INNER EAR; WITH CONTRAST MATERIAL(S)					
710	70482	COMPUTERIZED AXIAL TOMOGRAPHY, ORBIT, SELLA, OR POSTERIOR FOSSA OR OUTER, MIDDLE, OR INNER EAR; WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS					
710	70486	COMPUTERIZED AXIAL TOMOGRAPHY, MAXILLOFACIAL AREA; WITHOUT CONTRAST MATERIAL					
710	70487	COMPUTERIZED AXIAL TOMOGRAPHY, MAXILLOFACIAL AREA; WITH CONTRAST MATERIAL(S)					
710	70488	COMPUTERIZED AXIAL TOMOGRAPHY, MAXILLOFACIAL AREA; WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS					
710	70490	COMPUTERIZED AXIAL TOMOGRAPHY, SOFT TISSUE NECK; WITHOUT CONTRAST MATERIAL					
710	70491	COMPUTERIZED AXIAL TOMOGRAPHY, SOFT TISSUE NECK; WITH CONTRAST MATERIAL(S)					
710	70492	COMPUTERIZED AXIAL TOMOGRAPHY, SOFT TISSUE NECK; WITHOUT CONTRAST MATERIAL FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS					
710	71250	COMPUTERIZED AXIAL TOMOGRAPHY, THORAX; WITHOUT CONTRAST MATERIAL					
710	71260	COMPUTERIZED AXIAL TOMOGRAPHY, THORAX; WITH CONTRAST MATERIAL(S)					
710	71270	COMPUTERIZED AXIAL TOMOGRAPHY, THORAX; WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS					
710	72125	COMPUTERIZED AXIAL TOMOGRAPHY, CERVICAL SPINE; WITHOUT CONTRAST MATERIAL					
710	72126	COMPUTERIZED AXIAL TOMOGRAPHY, CERVICAL SPINE; WITH CONTRAST MATERIAL					
710	72127	COMPUTERIZED AXIAL TOMOGRAPHY, CERVICAL SPINE; WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS					
710	72128	COMPUTERIZED AXIAL TOMOGRAPHY, THORACIC SPINE; WITHOUT CONTRAST MATERIAL					
710	72129	COMPUTERIZED AXIAL TOMOGRAPHY, THORACIC SPINE; WITH CONTRAST MATERIAL					
710	72130	COMPUTERIZED AXIAL TOMOGRAPHY, THORACIC SPINE; WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS					
710	72131	COMPUTERIZED AXIAL TOMOGRAPHY, LUMBAR SPINE; WITHOUT CONTRAST MATERIAL					
710	72132	COMPUTERIZED AXIAL TOMOGRAPHY, LUMBAR SPINE; WITH CONTRAST MATERIAL					
710	72133	COMPUTERIZED AXIAL TOMOGRAPHY, LUMBAR SPINE; WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS					
710	72192	COMPUTERIZED AXIAL TOMOGRAPHY, PELVIS; WITHOUT CONTRAST MATERIAL					
710	72193	COMPUTERIZED AXIAL TOMOGRAPHY, PELVIS; WITH CONTRAST MATERIAL(S)					

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
710	72194	COMPUTERIZED AXIAL TOMOGRAPHY, PELVIS; WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS					
710	73200	COMPUTERIZED AXIAL TOMOGRAPHY, UPPER EXTREMITY; WITHOUT CONTRAST MATERIAL					
710	73201	COMPUTERIZED AXIAL TOMOGRAPHY, UPPER EXTREMITY; WITH CONTRAST MATERIAL(S)					
710	73202	COMPUTERIZED AXIAL TOMOGRAPHY, UPPER EXTREMITY; WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS					
710	73700	COMPUTERIZED AXIAL TOMOGRAPHY, LOWER EXTREMITY; WITHOUT CONTRAST MATERIAL					
710	73701	COMPUTERIZED AXIAL TOMOGRAPHY, LOWER EXTREMITY; WITH CONTRAST MATERIAL(S)					
710	73702	COMPUTERIZED AXIAL TOMOGRAPHY, LOWER EXTREMITY; WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS					
710	74150	COMPUTERIZED AXIAL TOMOGRAPHY, ABDOMEN; WITHOUT CONTRAST MATERIAL					
710	74160	COMPUTERIZED AXIAL TOMOGRAPHY, ABDOMEN; WITH CONTRAST MATERIAL(S)					
710	74170	COMPUTERIZED AXIAL TOMOGRAPHY, ABDOMEN; WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS					
710	76355	COMPUTERIZED TOMOGRAPHY GUIDANCE FOR STEREOTACTIC LOCALIZATION					
710	76360	COMPUTERIZED TOMOGRAPHY GUIDANCE FOR NEEDLE BIOPSY, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
710	76365	COMPUTERIZED TOMOGRAPHY GUIDANCE FOR CYST ASPIRATION, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
710	76370	COMPUTERIZED TOMOGRAPHY GUIDANCE FOR PLACEMENT OF RADIATION THERAPY FIELDS					
710	76375	CORONAL, SAGITTAL, MULTIPLANAR, OBLIQUE, 3-DIMENSIONAL AND/OR HOLOGRAPHIC RECONSTRUCTION OF COMPUTERIZED TOMOGRAPHY, MAGNETIC RESONANCE IMAGING, OR OTHER TOMOGRAPHIC MODALITY					
710	76380	COMPUTERIZED TOMOGRAPHY, LIMITED OR LOCALIZED FOLLOW-UP STUDY					
716	Fluoroscopy		X	1.59	$80.56	$47.91	$16.11
716	70370	RADIOLOGIC EXAMINATION; PHARYNX OR LARYNX, INCLUDING FLUOROSCOPY AND/OR MAGNIFICATION TECHNIQUE					
716	70371	COMPLEX DYNAMIC PHARYNGEAL AND SPEECH EVALUATION BY CINE OR VIDEO RECORDING					
716	71023	RADIOLOGIC EXAMINATION, CHEST, TWO VIEWS, FRONTAL AND LATERAL; WITH FLUOROSCOPY					
716	71034	RADIOLOGIC EXAMINATION, CHEST, COMPLETE, MINIMUM OF FOUR VIEWS; WITH FLUOROSCOPY					
716	71036	NEEDLE BIOPSY OF INTRATHORACIC LESION, INCLUDING FOLLOW-UP FILMS, FLUOROSCOPIC LOCALIZATION ONLY, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
716	71038	FLUOROSCOPIC LOCALIZATION FOR TRANSBRONCHIAL BIOPSY OR BRUSHING					
716	71090	INSERTION PACEMAKER, FLUOROSCOPY AND RADIOGRAPHY, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
716	74340	INTRODUCTION OF LONG GASTROINTESTINAL TUBE (EG, MILLER-ABBOTT), INCLUDING MULTIPLE FLUOROSCOPIES AND FILMS, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
716	75989	RADIOLOGICAL GUIDANCE FOR PERCUTANEOUS DRAINAGE OF ABSCESS, OR SPECIMEN COLLECTION (IE, FLUOROSCOPY, ULTRASOUND, OR COMPUTED TOMOGRAPHY), WITH PLACEMENT OF INDWELLING CATHETER, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
716	76000	FLUOROSCOPY (SEPARATE PROCEDURE), UP TO ONE HOUR PHYSICIAN TIME, OTHER THAN 71023 OR 71034 (EG, CARDIAC FLUOROSCOPY)					
716	76001	FLUOROSCOPY, PHYSICIAN TIME MORE THAN ONE HOUR, ASSISTING A NON-RADIOLOGIC PHYSICIAN (EG, NEPHROSTOLITHOTOMY, ERCP, BRONCHOSCOPY, TRANSBRONCHIAL BIOPSY)					
716	76003	FLUOROSCOPIC LOCALIZATION FOR NEEDLE BIOPSY OR FINE NEEDLE ASPIRATION					
720	Magnetic Resonance Angiography		S	6.34	$321.24	206.11	$64.25
720	70541	MAGNETIC RESONANCE ANGIOGRAPHY, HEAD AND/OR NECK, WITH OR WITHOUT CONTRAST MATERIAL(S)					
726	Magnetic Resonance Imaging		S	7.96	$403.33	$258.09	$80.67
726	70336	MAGNETIC RESONANCE (EG, PROTON) IMAGING, TEMPOROMANDIBULAR JOINT					
726	70540	MAGNETIC RESONANCE (EG, PROTON) IMAGING, ORBIT, FACE, AND NECK					
726	70551	MAGNETIC RESONANCE (EG, PROTON) IMAGING, BRAIN (INCLUDING BRAIN STEM); WITHOUT CONTRAST MATERIAL					
726	70552	MAGNETIC RESONANCE (EG, PROTON) IMAGING, BRAIN (INCLUDING BRAIN STEM); WITH CONTRAST MATERIAL(S)					
726	70553	MAGNETIC RESONANCE (EG, PROTON) IMAGING, BRAIN (INCLUDING BRAIN STEM); WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES					
726	71550	MAGNETIC RESONANCE (EG, PROTON) IMAGING, CHEST (EG, FOR EVALUATION OF HILAR AND MEDIASTINAL LYMPHADENOPATHY)					
726	72141	MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND CONTENTS, CERVICAL; WITHOUT CONTRAST MATERIAL					
726	72142	MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND CONTENTS, CERVICAL; WITH CONTRAST MATERIAL(S)					
726	72146	MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND CONTENTS, THORACIC; WITHOUT CONTRAST MATERIAL					
726	72147	MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND CONTENTS, THORACIC; WITH CONTRAST MATERIAL(S)					
726	72148	MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND CONTENTS, LUMBAR; WITHOUT CONTRAST MATERIAL					
726	72149	MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND CONTENTS, LUMBAR; WITH CONTRAST MATERIAL(S)					
726	72156	MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND CONTENTS, WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES; CERVICAL					
726	72157	MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND CONTENTS, WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES; THORACIC					
726	72158	MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND CONTENTS, WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES; LUMBAR					
726	72196	MAGNETIC RESONANCE (EG, PROTON) IMAGING, PELVIS					
726	73220	MAGNETIC RESONANCE (EG, PROTON) IMAGING, UPPER EXTREMITY, OTHER THAN JOINT					
726	73221	MAGNETIC RESONANCE (EG, PROTON) IMAGING, ANY JOINT OF UPPER EXTREMITY					
726	73720	MAGNETIC RESONANCE (EG, PROTON) IMAGING, LOWER EXTREMITY, OTHER THAN JOINT					
726	73721	MAGNETIC RESONANCE (EG, PROTON) IMAGING, ANY JOINT OF LOWER EXTREMITY					
726	74181	MAGNETIC RESONANCE (EG, PROTON) IMAGING, ABDOMEN					
726	75552	CARDIAC MAGNETIC RESONANCE IMAGING FOR MORPHOLOGY; WITHOUT CONTRAST MATERIAL					
726	75553	CARDIAC MAGNETIC RESONANCE IMAGING FOR MORPHOLOGY; WITH CONTRAST MATERIAL					
726	75554	CARDIAC MAGNETIC RESONANCE IMAGING FOR FUNCTION, WITH OR WITHOUT MORPHOLOGY; COMPLETE STUDY					
726	75555	CARDIAC MAGNETIC RESONANCE IMAGING FOR FUNCTION, WITH OR WITHOUT MORPHOLOGY; LIMITED STUDY					
726	76093	MAGNETIC RESONANCE IMAGING, BREAST, WITHOUT AND/OR WITH CONTRAST MATERIAL(S); UNILATERAL					
726	76094	MAGNETIC RESONANCE IMAGING, BREAST, WITHOUT AND/OR WITH CONTRAST MATERIAL(S); BILATERAL					

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
726	76390	MAGNETIC RESONANCE SPECTROSCOPY					
726	76400	MAGNETIC RESONANCE (EG, PROTON) IMAGING, BONE MARROW BLOOD SUPPLY					
728	Myelography		S	4.07	$206.22	$113.23	$41.24
728	70010	MYELOGRAPHY, POSTERIOR FOSSA, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
728	70015	CISTERNOGRAPHY, POSITIVE CONTRAST, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
728	72240	MYELOGRAPHY, CERVICAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
728	72255	MYELOGRAPHY, THORACIC, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
728	72265	MYELOGRAPHY, LUMBOSACRAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
728	72270	MYELOGRAPHY, ENTIRE SPINAL CANAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
728	72285	DISKOGRAPHY, CERVICAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
728	72295	DISKOGRAPHY, LUMBAR, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
730	Arthography		S	2.48	$125.66	$72.09	$25.13
730	70332	TEMPOROMANDIBULAR JOINT ARTHROGRAPHY, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
730	73040	RADIOLOGIC EXAMINATION, SHOULDER, ARTHROGRAPHY, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
730	73085	RADIOLOGIC EXAMINATION, ELBOW, ARTHROGRAPHY, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
730	73115	RADIOLOGIC EXAMINATION, WRIST, ARTHROGRAPHY, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
730	73525	RADIOLOGIC EXAMINATION, HIP, ARTHROGRAPHY, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
730	73580	RADIOLOGIC EXAMINATION, KNEE, ARTHROGRAPHY, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
730	73615	RADIOLOGIC EXAMINATION, ANKLE, ARTHROGRAPHY, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
736	Digestive Radiology		S	1.85	$93.74	$54.24	$18.75
736	74210	RADIOLOGIC EXAMINATION; PHARYNX AND/OR CERVICAL ESOPHAGUS					
736	74220	RADIOLOGIC EXAMINATION; ESOPHAGUS					
736	74230	SWALLOWING FUNCTION, PHARYNX AND/OR ESOPHAGUS, WITH CINERADIOGRAPHY AND/OR VIDEO					
736	74240	RADIOLOGIC EXAMINATION, GASTROINTESTINAL TRACT, UPPER; WITH OR WITHOUT DELAYED FILMS, WITHOUT KUB					
736	74241	RADIOLOGIC EXAMINATION, GASTROINTESTINAL TRACT, UPPER; WITH OR WITHOUT DELAYED FILMS, WITH KUB					
736	74245	RADIOLOGIC EXAMINATION, GASTROINTESTINAL TRACT, UPPER; WITH SMALL BOWEL, INCLUDES MULTIPLE SERIAL FILMS					
736	74246	RADIOLOGICAL EXAMINATION, GASTROINTESTINAL TRACT, UPPER, AIR CONTRAST, WITH SPECIFIC HIGH DENSITY BARIUM, EFFERVESCENT AGENT, WITH OR WITHOUT GLUCAGON; WITH OR WITHOUT DELAYED FILMS, WITHOUT KUB					
736	74247	RADIOLOGICAL EXAMINATION, GASTROINTESTINAL TRACT, UPPER, AIR CONTRAST, WITH SPECIFIC HIGH DENSITY BARIUM, EFFERVESCENT AGENT, WITH OR WITHOUT GLUCAGON; WITH OR WITHOUT DELAYED FILMS, WITH KUB					
736	74249	RADIOLOGICAL EXAMINATION, GASTROINTESTINAL TRACT, UPPER, AIR CONTRAST, WITH SPECIFIC HIGH DENSITY BARIUM, EFFERVESCENT AGENT, WITH OR WITHOUT GLUCAGON; WITH SMALL BOWEL FOLLOW-THROUGH					
736	74250	RADIOLOGIC EXAMINATION, SMALL BOWEL, INCLUDES MULTIPLE SERIAL FILMS;					
736	74251	RADIOLOGIC EXAMINATION, SMALL BOWEL, INCLUDES MULTIPLE SERIAL FILMS; VIA ENTEROCLYSIS TUBE					
736	74260	DUODENOGRAPHY, HYPOTONIC					
736	74270	RADIOLOGIC EXAMINATION, COLON; BARIUM ENEMA, WITH OR WITHOUT KUB					
736	74280	RADIOLOGIC EXAMINATION, COLON; AIR CONTRAST WITH SPECIFIC HIGH DENSITY BARIUM, WITH OR WITHOUT GLUCAGON					
736	74283	THERAPEUTIC ENEMA, CONTRAST OR AIR, FOR REDUCTION OF INTUSSUSCEPTION OR OTHER INTRALUMINAL OBSTRUCTION (EG, MECONIUM ILEUS)					
736	74290	CHOLECYSTOGRAPHY, ORAL CONTRAST;					
736	74291	CHOLECYSTOGRAPHY, ORAL CONTRAST; ADDITIONAL OR REPEAT EXAMINATION OR MULTIPLE DAY EXAMINATION					
736	G0106	Colorectal Ca screening					
736	G0120	Colorectal Ca screening					
737	Diagnostic Urography		S	2.81	$142.38	$86.56	$28.48
737	74400	UROGRAPHY (PYELOGRAPHY), INTRAVENOUS, WITH OR WITHOUT KUB, WITH OR WITHOUT TOMOGRAPHY;					
737	74405	UROGRAPHY (PYELOGRAPHY), INTRAVENOUS, WITH OR WITHOUT KUB, WITH OR WITHOUT TOMOGRAPHY; WITH SPECIAL HYPERTENSIVE CONTRAST CONCENTRATION AND/OR CLEARANCE STUDIES					
737	74410	UROGRAPHY, INFUSION, DRIP TECHNIQUE AND/OR BOLUS TECHNIQUE;					
737	74415	UROGRAPHY, INFUSION, DRIP TECHNIQUE AND/OR BOLUS TECHNIQUE; WITH NEPHROTOMOGRAPHY					
737	74420	UROGRAPHY, RETROGRADE, WITH OR WITHOUT KUB					
737	74425	UROGRAPHY, ANTEGRADE, (PYELOSTOGRAM, NEPHROSTOGRAM, LOOPOGRAM), RADIOLOGICAL SUPERVISION AND					
737	74430	CYSTOGRAPHY, MINIMUM OF THREE VIEWS, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
737	74440	VASOGRAPHY, VESICULOGRAPHY, OR EPIDIDYMOGRAPHY, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
737	74445	CORPORA CAVERNOSOGRAPHY, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
737	74450	URETHROCYSTOGRAPHY, RETROGRADE, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
737	74455	URETHROCYSTOGRAPHY, VOIDING, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
737	74775	PERINEOGRAM (EG, VAGINOGRAM, FOR SEX DETERMINATION OR EXTENT OF ANOMALIES)					
738	Therapeutic Radiologic Procedures		S	4.48	$227.00	$133.23	$45.4
738	74235	REMOVAL OF FOREIGN BODY(S), ESOPHAGEAL, WITH USE OF BALLOON CATHETER, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
738	74327	POSTOPERATIVE BILIARY DUCT STONE REMOVAL, PERCUTANEOUS VIA T-TUBE TRACT, BASKET, OR SNARE (EG, BURHENNE TECHNIQUE), RADIOLOGICAL SUPERVISION AND INTERPRETATION					
738	74360	INTRALUMINAL DILATION OF STRICTURES AND/OR OBSTRUCTIONS (EG, ESOPHAGUS), RADIOLOGICAL SUPERVISION AND INTERPRETATION					
738	74363	PERCUTANEOUS TRANSHEPATIC DILATATION OF BILIARY DUCT STRICTURE WITH OR WITHOUT PLACEMENT OF STENT, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
738	74475	INTRODUCTION OF INTRACATHETER OR CATHETER INTO RENAL PELVIS FOR DRAINAGE AND/OR INJECTION, PERCUTANEOUS, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
738	74480	INTRODUCTION OF URETERAL CATHETER OR STENT INTO URETER THROUGH RENAL PELVIS FOR DRAINAGE AND/OR INJECTION, PERCUTANEOUS, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
738	74485	DILATION OF NEPHROSTOMY, URETERS, OR URETHRA, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
738	75980	PERCUTANEOUS TRANSHEPATIC BILIARY DRAINAGE WITH CONTRAST MONITORING, RADIOLOGICAL SUPERVISION AND INTERPRETATION					

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
738	75982	PERCUTANEOUS PLACEMENT OF DRAINAGE CATHETER FOR COMBINED INTERNAL AND EXTERNAL BILIARY DRAINAGE OR OF A DRAINAGE STENT FOR INTERNAL BILIARY DRAINAGE IN PATIENTS WITH AN INOPERABLE MECHANICAL BILIARY OBSTRUCTION, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
738	75984	CHANGE OF PERCUTANEOUS TUBE OR DRAINAGE CATHETER WITH CONTRAST MONITORING (EG, GASTROINTESTINAL SYSTEM, GENITOURINARY SYSTEM, ABSCESS), RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	Diagnostic	Angiography and Venography	S	5.83	$295.40	$168.71	$59.08
739	75600	AORTOGRAPHY, THORACIC, WITHOUT SERIALOGRAPHY, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75605	AORTOGRAPHY, THORACIC, BY SERIALOGRAPHY, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75625	AORTOGRAPHY, ABDOMINAL, BY SERIALOGRAPHY, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75630	AORTOGRAPHY, ABDOMINAL PLUS BILATERAL ILIOFEMORAL LOWER EXTREMITY, CATHETER, BY SERIALOGRAPHY, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75650	ANGIOGRAPHY, CERVICOCEREBRAL, CATHETER, INCLUDING VESSEL ORIGIN, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75658	ANGIOGRAPHY, BRACHIAL, RETROGRADE, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75660	ANGIOGRAPHY, EXTERNAL CAROTID, UNILATERAL, SELECTIVE, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75662	ANGIOGRAPHY, EXTERNAL CAROTID, BILATERAL, SELECTIVE, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75665	ANGIOGRAPHY, CAROTID, CEREBRAL, UNILATERAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75671	ANGIOGRAPHY, CAROTID, CEREBRAL, BILATERAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75676	ANGIOGRAPHY, CAROTID, CERVICAL, UNILATERAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75680	ANGIOGRAPHY, CAROTID, CERVICAL, BILATERAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75685	ANGIOGRAPHY, VERTEBRAL, CERVICAL, AND/OR INTRACRANIAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75705	ANGIOGRAPHY, SPINAL, SELECTIVE, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75710	ANGIOGRAPHY, EXTREMITY, UNILATERAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75716	ANGIOGRAPHY, EXTREMITY, BILATERAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75722	ANGIOGRAPHY, RENAL, UNILATERAL, SELECTIVE (INCLUDING FLUSH AORTOGRAM), RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75724	ANGIOGRAPHY, RENAL, BILATERAL, SELECTIVE (INCLUDING FLUSH AORTOGRAM), RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75726	ANGIOGRAPHY, VISCERAL, SELECTIVE OR SUPRASELECTIVE, (WITH OR WITHOUT FLUSH AORTOGRAM), RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75731	ANGIOGRAPHY, ADRENAL, UNILATERAL, SELECTIVE, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75733	ANGIOGRAPHY, ADRENAL, BILATERAL, SELECTIVE, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75736	ANGIOGRAPHY, PELVIC, SELECTIVE OR SUPRASELECTIVE, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75741	ANGIOGRAPHY, PULMONARY, UNILATERAL, SELECTIVE, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75743	ANGIOGRAPHY, PULMONARY, BILATERAL, SELECTIVE, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75746	ANGIOGRAPHY, PULMONARY, BY NONSELECTIVE CATHETER OR VENOUS INJECTION, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75756	ANGIOGRAPHY, INTERNAL MAMMARY, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75774	ANGIOGRAPHY, SELECTIVE, EACH ADDITIONAL VESSEL STUDIED AFTER BASIC EXAMINATION, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75790	ANGIOGRAPHY, ARTERIOVENOUS SHUNT (EG, DIALYSIS PATIENT), RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75810	SPLENOPORTOGRAPHY, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75820	VENOGRAPHY, EXTREMITY, UNILATERAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75822	VENOGRAPHY, EXTREMITY, BILATERAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75825	VENOGRAPHY, CAVAL, INFERIOR, WITH SERIALOGRAPHY, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75827	VENOGRAPHY, CAVAL, SUPERIOR, WITH SERIALOGRAPHY, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75831	VENOGRAPHY, RENAL, UNILATERAL, SELECTIVE, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75833	VENOGRAPHY, RENAL, BILATERAL, SELECTIVE, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75840	VENOGRAPHY, ADRENAL, UNILATERAL, SELECTIVE, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75842	VENOGRAPHY, ADRENAL, BILATERAL, SELECTIVE, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75860	VENOGRAPHY, SINUS OR JUGULAR, CATHETER, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75870	VENOGRAPHY, SUPERIOR SAGITTAL SINUS, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75872	VENOGRAPHY, EPIDURAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75880	VENOGRAPHY, ORBITAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75885	PERCUTANEOUS TRANSHEPATIC PORTOGRAPHY WITH HEMODYNAMIC EVALUATION, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75887	PERCUTANEOUS TRANSHEPATIC PORTOGRAPHY WITHOUT HEMODYNAMIC EVALUATION, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75889	HEPATIC VENOGRAPHY, WEDGED OR FREE, WITH HEMODYNAMIC EVALUATION, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
739	75891	HEPATIC VENOGRAPHY, WEDGED OR FREE, WITHOUT HEMODYNAMIC EVALUATION, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
746	Mammography		S	0.69	$34.96	$19.44	$6.99
746	76090	MAMMOGRAPHY; UNILATERAL					
746	76091	MAMMOGRAPHY; BILATERAL					
747	Diagnostic	Ultrasound Except Vascular	S	1.65	$83.60	$54.69	$16.72
747	76506	ECHOENCEPHALOGRAPHY, B-SCAN AND/OR REAL TIME WITH IMAGE DOCUMENTATION (GRAY SCALE) (FOR DETERMINATION OF VENTRICULAR SIZE, DELINEATION OF CEREBRAL CONTENTS AND DETECTION OF FLUID MASSES OR OTHER INTRACRANIAL ABNORMALITIES), INCLUDING A-MODE ENCEPHALOGRAPH					
747	76511	OPHTHALMIC ULTRASOUND, ECHOGRAPHY, DIAGNOSTIC; A-SCAN ONLY, WITH AMPLITUDE QUANTIFICATION					
747	76512	OPHTHALMIC ULTRASOUND, ECHOGRAPHY, DIAGNOSTIC; CONTACT B-SCAN (WITH OR WITHOUT SIMULTANEOUS A-SCAN)					
747	76513	OPHTHALMIC ULTRASOUND, ECHOGRAPHY, DIAGNOSTIC; IMMERSION (WATER BATH) B-SCAN					
747	76516	OPHTHALMIC BIOMETRY BY ULTRASOUND ECHOGRAPHY, A-SCAN;					
747	76519	OPHTHALMIC BIOMETRY BY ULTRASOUND ECHOGRAPHY, A-SCAN; WITH INTRAOCULAR LENS POWER CALCULATION					
747	76529	OPHTHALMIC ULTRASONIC FOREIGN BODY LOCALIZATION					

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
747	76536	ECHOGRAPHY, SOFT TISSUES OF HEAD AND NECK (EG, THYROID, PARATHYROID, PAROTID), B-SCAN AND/OR REAL TIME WITH IMAGE DOCUMENTATION					
747	76604	ECHOGRAPHY, CHEST, B-SCAN (INCLUDES MEDIASTINUM) AND/OR REAL TIME WITH IMAGE DOCUMENTATION					
747	76645	ECHOGRAPHY, BREAST(S) (UNILATERAL OR BILATERAL), B-SCAN AND/ OR REAL TIME WITH IMAGE DOCUMENTATION					
747	76700	ECHOGRAPHY, ABDOMINAL, B-SCAN AND/OR REAL TIME WITH IMAGE DOCUMENTATION; COMPLETE					
747	76705	ECHOGRAPHY, ABDOMINAL, B-SCAN AND/OR REAL TIME WITH IMAGE DOCUMENTATION; LIMITED (EG, SINGLE ORGAN, QUADRANT, FOLLOW-UP)					
747	76770	ECHOGRAPHY, RETROPERITONEAL (EG, RENAL, AORTA, NODES), B-SCAN AND/OR REAL TIME WITH IMAGE DOCUMENTATION; COMPLETE					
747	76775	ECHOGRAPHY, RETROPERITONEAL (EG, RENAL, AORTA, NODES), B-SCAN AND/OR REAL TIME WITH IMAGE DOCUMENTATION; LIMITED					
747	76778	ECHOGRAPHY OF TRANSPLANTED KIDNEY, B-SCAN AND/OR REAL TIME WITH IMAGE DOCUMENTATION, WITH OR WITHOUT DUPLEX DOPPLER STUDIES					
747	76800	ECHOGRAPHY, SPINAL CANAL AND CONTENTS					
747	76805	ECHOGRAPHY, PREGNANT UTERUS, B-SCAN AND/OR REAL TIME WITH IMAGE DOCUMENTATION; COMPLETE (COMPLETE FETAL AND MATERNAL EVALUATION)					
747	76810	ECHOGRAPHY, PREGNANT UTERUS, B-SCAN AND/OR REAL TIME WITH IMAGE DOCUMENTATION; COMPLETE (COMPLETE FETAL AND MATERNAL EVALUATION), MULTIPLE GESTATION, AFTER THE FIRST TRIMESTER					
747	76815	ECHOGRAPHY, PREGNANT UTERUS, B-SCAN AND/OR REAL TIME WITH IMAGE DOCUMENTATION; LIMITED (FETAL SIZE, HEART BEAT, PLACENTAL LOCATION, FETAL POSITION, OR EMERGENCY IN THE DELIVERY ROOM)					
747	76816	ECHOGRAPHY, PREGNANT UTERUS, B-SCAN AND/OR REAL TIME WITH IMAGE DOCUMENTATION; FOLLOW-UP OR REPEAT					
747	76818	FETAL BIOPHYSICAL PROFILE					
747	76830	ECHOGRAPHY, TRANSVAGINAL					
747	76831	HYSTEROSONOGRAPHY, WITH OR WITHOUT COLOR FLOW DOPPLER					
747	76856	ECHOGRAPHY, PELVIC (NONOBSTETRIC), B-SCAN AND/OR REAL TIME WITH IMAGE DOCUMENTATION; COMPLETE					
747	76857	ECHOGRAPHY, PELVIC (NONOBSTETRIC), B-SCAN AND/OR REAL TIME WITH IMAGE DOCUMENTATION; LIMITED OR FOLLOW-UP (EG, FOR FOLLICLES)					
747	76870	ECHOGRAPHY, SCROTUM AND CONTENTS					
747	76872	ECHOGRAPHY, TRANSRECTAL					
747	76880	ECHOGRAPHY, EXTREMITY, NON-VASCULAR, B-SCAN AND/OR REAL TIME WITH IMAGE DOCUMENTATION					
747	76885	ECHOGRAPHY OF INFANT HIPS, REAL TIME WITH IMAGING DOCUMENTATION; DYNAMIC (EG, REQUIRING MANIPULATION)					
747	76886	ECHOGRAPHY OF INFANT HIPS, REAL TIME WITH IMAGING DOCUMENTATION; LIMITED, STATIC (EG, NOT REQUIRING MANIPULATION					
747	76970	ULTRASOUND STUDY FOLLOW-UP (SPECIFY)					
747	76975	GASTROINTESTINAL ENDOSCOPIC ULTRASOUND, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
747	76986	ECHOGRAPHY, INTRAOPERATIVE					
747	76999	UNLISTED ULTRASOUND PROCEDURE					
747	G0050	POST-VOIDAL RESIDUAL URINE/BLADDER CAPACITY					
749	Guidance under Ultrasound		X	2.44	$123.63	$76.16	$24.73
749	76930	ULTRASONIC GUIDANCE FOR PERICARDIOCENTESIS, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
749	76932	ULTRASONIC GUIDANCE FOR ENDOMYOCARDIAL BIOPSY, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
749	76934	ULTRASONIC GUIDANCE FOR THORACENTESIS OR ABDOMINAL PARACENTESIS, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
749	76936	ULTRASOUND GUIDED COMPRESSION REPAIR OF ARTERIAL PSEUDO-ANEURYSM OR ARTERIOVENOUS FISTULAE (INCLUDES DIAGNOSTIC ULTRASOUND EVALUATION, COMPRESSION OF LESION AND IMAGING)					
749	76938	ULTRASONIC GUIDANCE FOR CYST (ANY LOCATION) OR RENAL PELVIS ASPIRATION, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
749	76941	ULTRASONIC GUIDANCE FOR INTRAUTERINE FETAL TRANSFUSION OR CORDOCENTESIS, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
749	76942	ULTRASONIC GUIDANCE FOR NEEDLE BIOPSY, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
749	76945	ULTRASONIC GUIDANCE FOR CHORIONIC VILLUS SAMPLING, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
749	76946	ULTRASONIC GUIDANCE FOR AMNIOCENTESIS, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
749	76948	ULTRASONIC GUIDANCE FOR ASPIRATION OF OVA, RADIOLOGICAL SUPERVISION AND INTERPRETATION					
749	76950	ECHOGRAPHY FOR PLACEMENT OF RADIATION THERAPY FIELDS, B-SCAN					
749	76960	ULTRASONIC GUIDANCE FOR PLACEMENT OF RADIATION THERAPY FIELDS, EXCEPT FOR B-SCAN ECHOGRAPHY					
749	76965	ULTRASONIC GUIDANCE FOR INTERSTITIAL RADIOELEMENT APPLICATION					
750	Therapeutic Radiation Treatment Planning		X	0.91	$46.11	$25.54	$9.22
750	77261	THERAPEUTIC RADIOLOGY TREATMENT PLANNING; SIMPLE					
750	77262	THERAPEUTIC RADIOLOGY TREATMENT PLANNING; INTERMEDIATE					
750	77263	THERAPEUTIC RADIOLOGY TREATMENT PLANNING; COMPLEX					
750	77336	CONTINUING MEDICAL RADIATION PHYSICS CONSULTATION IN SUPPORT OF THERAPEUTIC RADIOLOGIST INCLUDING CONTINUING QUALITY ASSURANCE REPORTED PER WEEK OF THERAPY					
750	77370	SPECIAL MEDICAL RADIATION PHYSICS CONSULTATION					
750	77399	UNLISTED PROCEDURE, MEDICAL RADIATION PHYSICS, DOSIMETRY AND TREATMENT DEVICES					
750	77431	RADIATION THERAPY MANAGEMENT WITH COMPLETE COURSE OF THERAPY CONSISTING OF ONE OR TWO FRACTIONS ONLY					
750	77432	STEREOTACTIC RADIATION TREATMENT MANAGEMENT OF CEREBRAL LESION(S) (COMPLETE COURSE OF TREATMENT CONSISTING OF ONE SESSION)					
751	Level I Therapeutic Radiation Treatment Preparation		X	1.15	$58.27	$33.22	$11.65
751	77299	UNLISTED PROCEDURE, THERAPEUTIC RADIOLOGY CLINICAL TREATMENT PLANNING					
751	77300	BASIC RADIATION DOSIMETRY CALCULATION, CENTRAL AXIS DEPTH DOSE, TDF, NSD, GAP CALCULATION, OFF AXIS FACTOR, TISSUE INHOMOGENEITY FACTORS, AS REQUIRED DURING COURSE OF TREATMENT, ONLY WHEN PRESCRIBED BY THE TREATING PHYSICIAN					
751	77305	TELETHERAPY, ISODOSE PLAN (WHETHER HAND OR COMPUTER CALCULATED); SIMPLE (ONE OR TWO PARALLEL OPPOSED UNMODIFIED PORTS DIRECTED TO A SINGLE AREA OF INTEREST)					

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
751	77310	TELETHERAPY, ISODOSE PLAN (WHETHER HAND OR COMPUTER CALCULATED); INTERMEDIATE (THREE OR MORE TREATMENT PORTS DIRECTED TO A SINGLE AREA OF INTEREST)					
751	77315	TELETHERAPY, ISODOSE PLAN (WHETHER HAND OR COMPUTER CALCULATED); COMPLEX (MANTLE OR INVERTED Y, TANGENTIAL PORTS, THE USE OF WEDGES, COMPENSATORS, COMPLEX BLOCKING, ROTATIONAL BEAM, OR SPECIAL BEAM CONSIDERATIONS)					
751	77321	SPECIAL TELETHERAPY PORT PLAN, PARTICLES, HEMIBODY, TOTAL BODY					
751	77326	BRACHYTHERAPY ISODOSE CALCULATION; SIMPLE (CALCULATION MADE FROM SINGLE PLANE, ONE TO FOUR SOURCES/ RIBBON APPLICATION, REMOTE AFTERLOADING BRACHYTHERAPY, 1 TO 8 SOURCES)					
751	77327	BRACHYTHERAPY ISODOSE CALCULATION; INTERMEDIATE (MULTIPLANE DOSAGE CALCULATIONS, APPLICATION INVOLVING 5 TO 10 SOURCES/RIBBONS, REMOTE AFTERLOADING BRACHYTHERAPY, 9 TO 12 SOURCES)					
751	77328	BRACHYTHERAPY ISODOSE CALCULATION; COMPLEX (MULTIPLANE ISODOSE PLAN, VOLUME IMPLANT CALCULATIONS, OVER 10 SOURCES/RIBBONS USED, SPECIAL SPATIAL RECONSTRUCTION, REMOTE AFTERLOADING BRACHYTHERAPY, OVER 12 SOURCES)					
751	77331	SPECIAL DOSIMETRY (EG, TLD, MICRODOSIMETRY) (SPECIFY), ONLY WHEN PRESCRIBED BY THE TREATING PHYSICIAN					
751	77332	TREATMENT DEVICES, DESIGN AND CONSTRUCTION; SIMPLE (SIMPLE BLOCK, SIMPLE BOLUS)					
751	77333	TREATMENT DEVICES, DESIGN AND CONSTRUCTION; INTERMEDIATE (MULTIPLE BLOCKS, STENTS, BITE BLOCKS, SPECIAL BOLUS)					
751	77334	TREATMENT DEVICES, DESIGN AND CONSTRUCTION; COMPLEX (IRREGULAR BLOCKS, SPECIAL SHIELDS, COMPENSATORS, WEDGES, MOLDS OR CASTS)					
752	Level II Therapeutic Radiation Treatment		X	3.54	$179.37	$88.82	$35.87
752	77280	THERAPEUTIC RADIOLOGY SIMULATION-AIDED FIELD SETTING; SIMPLE					
752	77285	THERAPEUTIC RADIOLOGY SIMULATION-AIDED FIELD SETTING; INTERMEDIATE					
752	77290	THERAPEUTIC RADIOLOGY SIMULATION-AIDED FIELD SETTING; COMPLEX					
752	77295	THERAPEUTIC RADIOLOGY SIMULATION-AIDED FIELD SETTING; THREE-DIMENSIONAL					
757	Radiation Therapy		S	2.30	$116.54	$52.43	$23.31
757	61793	STEREOTACTIC RADIOSURGERY (PARTICLE BEAM, GAMMA RAY OR LINEAR ACCELERATOR), ONE OR MORE SESSIONS					
757	77401	RADIATION TREATMENT DELIVERY, SUPERFICIAL AND/OR ORTHO VOLTAGE					
757	77402	RADIATION TREATMENT DELIVERY, SINGLE TREATMENT AREA, SINGLE PORT OR PARALLEL OPPOSED PORTS, SIMPLE BLOCKS OR NO BLOCKS; UP TO 5 MEV					
757	77403	RADIATION TREATMENT DELIVERY, SINGLE TREATMENT AREA, SINGLE PORT OR PARALLEL OPPOSED PORTS, SIMPLE BLOCKS OR NO BLOCKS; 6-10 MEV					
757	77404	RADIATION TREATMENT DELIVERY, SINGLE TREATMENT AREA, SINGLE PORT OR PARALLEL OPPOSED PORTS, SIMPLE BLOCKS OR NO BLOCKS; 11-19 MEV					
757	77406	RADIATION TREATMENT DELIVERY, SINGLE TREATMENT AREA, SINGLE PORT OR PARALLEL OPPOSED PORTS, SIMPLE BLOCKS OR NO BLOCKS; 20 MEV OR GREATER					
757	77407	RADIATION TREATMENT DELIVERY, TWO SEPARATE TREATMENT AREAS, THREE OR MORE PORTS ON A SINGLE TREATMENT AREA, USE OF MULTIPLE BLOCKS; UP TO 5 MEV					
757	77408	RADIATION TREATMENT DELIVERY, TWO SEPARATE TREATMENT AREAS, THREE OR MORE PORTS ON A SINGLE TREATMENT AREA, USE OF MULTIPLE BLOCKS; 6-10 MEV					
757	77409	RADIATION TREATMENT DELIVERY, TWO SEPARATE TREATMENT AREAS, THREE OR MORE PORTS ON A SINGLE TREATMENT AREA, USE OF MULTIPLE BLOCKS; 11-19 MEV					
757	77411	RADIATION TREATMENT DELIVERY, TWO SEPARATE TREATMENT AREAS, THREE OR MORE PORTS ON A SINGLE TREATMENT AREA, USE OF MULTIPLE BLOCKS; 20 MEV OR GREATER					
757	77412	RADIATION TREATMENT DELIVERY, THREE OR MORE SEPARATE TREATMENT AREAS, CUSTOM BLOCKING, TANGENTIAL PORTS, WEDGES, ROTATIONAL BEAM, COMPENSATORS, SPECIAL PARTICLE BEAM (EG, ELECTRON OR NEUTRONS); UP TO 5 MEV					
757	77413	RADIATION TREATMENT DELIVERY, THREE OR MORE SEPARATE TREATMENT AREAS, CUSTOM BLOCKING, TANGENTIAL PORTS, WEDGES, ROTATIONAL BEAM, COMPENSATORS, SPECIAL PARTICLE BEAM (EG, ELECTRON OR NEUTRONS); 6-10 MEV					
757	77414	RADIATION TREATMENT DELIVERY, THREE OR MORE SEPARATE TREATMENT AREAS, CUSTOM BLOCKING, TANGENTIAL PORTS, WEDGES, ROTATIONAL BEAM, COMPENSATORS, SPECIAL PARTICLE BEAM (EG, ELECTRON OR NEUTRONS); 11-19 MEV					
757	77416	RADIATION TREATMENT DELIVERY, THREE OR MORE SEPARATE TREATMENT AREAS, CUSTOM BLOCKING, TANGENTIAL PORTS, WEDGES, ROTATIONAL BEAM, COMPENSATORS, SPECIAL PARTICLE BEAM (EG, ELECTRON OR NEUTRONS); 20 MEV OR GREATER					
757	77470	SPECIAL TREATMENT PROCEDURE (EG, TOTAL BODY IRRADIATION, HEMIBODY IRRADIATION, PER ORAL, VAGINAL CONE IRRADIATION					
758	Hyperthermic Therapies		S	3.41	$172.78	$76.84	$34.56
758	77600	HYPERTHERMIA, EXTERNALLY GENERATED; SUPERFICIAL (IE, HEATING TO A DEPTH OF 4 CM OR LESS)					
758	77605	HYPERTHERMIA, EXTERNALLY GENERATED; DEEP (IE, HEATING TO DEPTHS GREATER THAN 4 CM)					
758	77610	HYPERTHERMIA GENERATED BY INTERSTITIAL PROBE(S); 5 OR FEWER INTERSTITIAL APPLICATORS					
758	77615	HYPERTHERMIA GENERATED BY INTERSTITIAL PROBE(S); MORE THAN 5 INTERSTITIAL APPLICATORS					
758	77620	HYPERTHERMIA GENERATED BY INTRACAVITARY PROBE(S)					
759	Brachytherapy and Complex Radioelement Applications		S	7.98	$404.34	$160.01	$80.87
759	77750	INFUSION OR INSTILLATION OF RADIOELEMENT SOLUTION					
759	77761	INTRACAVITARY RADIOELEMENT APPLICATION; SIMPLE					
759	77762	INTRACAVITARY RADIOELEMENT APPLICATION; INTERMEDIATE					
759	77763	INTRACAVITARY RADIOELEMENT APPLICATION; COMPLEX					
759	77776	INTERSTITIAL RADIOELEMENT APPLICATION; SIMPLE					
759	77777	INTERSTITIAL RADIOELEMENT APPLICATION; INTERMEDIATE					
759	77778	INTERSTITIAL RADIOELEMENT APPLICATION; COMPLEX					
759	77781	REMOTE AFTERLOADING HIGH INTENSITY BRACHYTHERAPY; 1-4 SOURCE POSITIONS OR CATHETERS					
759	77782	REMOTE AFTERLOADING HIGH INTENSITY BRACHYTHERAPY; 5-8 SOURCE POSITIONS OR CATHETERS					
759	77783	REMOTE AFTERLOADING HIGH INTENSITY BRACHYTHERAPY; 9-12 SOURCE POSITIONS OR CATHETERS					
759	77784	REMOTE AFTERLOADING HIGH INTENSITY BRACHYTHERAPY; OVER 12 SOURCE POSITIONS OR CATHETERS					
759	77789	SURFACE APPLICATION OF RADIOELEMENT					
759	77799	UNLISTED PROCEDURE, CLINICAL BRACHYTHERAPY					
760	PET Scans		S	17.26	$874.55	$419.46	$174.91
760	78459	MYOCARDIAL IMAGING, POSITRON EMISSION TOMOGRAPHY (PET), METABOLIC EVALUATION					

(See Addendum D. for Payment of Medical Visits)

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[2] Copyright 1994 American Dental Association. All rights reserved.

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
760	78608	BRAIN IMAGING, POSITRON EMISSION TOMOGRAPHY (PET); METABOLIC EVALUATION					
760	78609	BRAIN IMAGING, POSITRON EMISSION TOMOGRAPHY (PET); PERFUSION EVALUATION					
760	78810	TUMOR IMAGING, POSITRON EMISSION TOMOGRAPHY (PET), METABOLIC EVALUATION					
760	G0030	PET imaging prev PET single					
760	G0031	PET imaging prev PET multple					
760	G0032	PET follow SPECT 78464 singl					
760	G0033	PET follow SPECT 78464 mult					
760	G0034	PET follow SPECT 76865 singl					
760	G0035	PET follow SPECT 78465 mult					
760	G0036	PET follow cornry angio sing					
760	G0037	PET follow cornry angio mult					
760	G0038	PET follow myocard perf sing					
760	G0039	PET follow myocard perf mult					
760	G0040	PET follow stress echo singl					
760	G0041	PET follow stress echo mult					
760	G0042	PET follow ventriculogm sing					
760	G0043	PET follow ventriculogm mult					
760	G0044	PET following rest ECG singl					
760	G0045	PET following rest ECG mult					
760	G0046	PET follow stress ECG singl					
760	G0047	PET follow stress ECG mult					
761	Standard	Non-Imaging Nuclear Medicine	S	2.04	$103.37	$61.47	$20.67
761	78000	THYROID UPTAKE; SINGLE DETERMINATION					
761	78099	UNLISTED ENDOCRINE PROCEDURE, DIAGNOSTIC NUCLEAR MEDICINE					
761	78110	PLASMA VOLUME, RADIOPHARMACEUTICAL VOLUME-DILUTION TECHNIQUE (SEPARATE PROCEDURE); SINGLE SAMPLING					
761	78111	PLASMA VOLUME, RADIOPHARMACEUTICAL VOLUME-DILUTION TECHNIQUE (SEPARATE PROCEDURE); MULTIPLE SAMPLINGS					
761	78120	RED CELL VOLUME DETERMINATION (SEPARATE PROCEDURE); SINGLE SAMPLING					
761	78199	UNLISTED HEMATOPOIETIC, RETICULOENDOTHELIAL AND LYMPHATIC PROCEDURE, DIAGNOSTIC NUCLEAR MEDICINE					
761	78270	VITAMIN B-12 ABSORPTION STUDY (EG, SCHILLING TEST); WITHOUT INTRINSIC FACTOR					
761	78271	VITAMIN B-12 ABSORPTION STUDY (EG, SCHILLING TEST); WITH INTRINSIC FACTOR					
761	78272	VITAMIN B-12 ABSORPTION STUDIES COMBINED, WITH AND WITHOUT INTRINSIC FACTOR					
761	78282	GASTROINTESTINAL PROTEIN LOSS					
761	78299	UNLISTED GASTROINTESTINAL PROCEDURE, DIAGNOSTIC NUCLEAR MEDICINE					
761	78725	KIDNEY FUNCTION STUDY WITHOUT PHARMACOLOGIC INTERVENTION					
761	78999	UNLISTED MISCELLANEOUS PROCEDURE, DIAGNOSTIC NUCLEAR MEDICINE					
762	Complex	Non-Imaging Nuclear Medicine	S	1.78	$90.19	$51.53	$18.04
762	78001	THYROID UPTAKE; MULTIPLE DETERMINATIONS					
762	78003	THYROID UPTAKE; STIMULATION, SUPPRESSION OR DISCHARGE (NOT INCLUDING INITIAL UPTAKE STUDIES)					
762	78121	RED CELL VOLUME DETERMINATION (SEPARATE PROCEDURE); MULTIPLE SAMPLINGS					
762	78122	WHOLE BLOOD VOLUME DETERMINATION, INCLUDING SEPARATE MEASUREMENT OF PLASMA VOLUME AND RED CELL VOLUME (RADIOPHARMACEUTICAL VOLUME-DILUTION TECHNIQUE)					
762	78130	RED CELL SURVIVAL STUDY;					
762	78135	RED CELL SURVIVAL STUDY; DIFFERENTIAL ORGAN/TISSUE KINETICS, (EG, SPLENIC AND/OR HEPATIC SEQUESTRATION)					
762	78140	LABELED RED CELL SEQUESTRATION, DIFFERENTIAL ORGAN/TISSUE, (EG, SPLENIC AND/OR HEPATIC)					
762	78160	PLASMA RADIOIRON DISAPPEARANCE (TURNOVER) RATE					
762	78162	RADIOIRON ORAL ABSORPTION					
762	78170	RADIOIRON RED CELL UTILIZATION					
762	78172	CHELATABLE IRON FOR ESTIMATION OF TOTAL BODY IRON					
762	78190	KINETICS, STUDY OF PLATELET SURVIVAL, WITH OR WITHOUT DIFFERENTIAL ORGAN/TISSUE LOCALIZATION					
762	78191	PLATELET SURVIVAL STUDY					
762	78414	DETERMINATION OF CENTRAL C-V HEMODYNAMICS (NON-IMAGING) (EG, EJECTION FRACTION WITH PROBE TECHNIQUE) WITH OR WITHOUT PHARMACOLOGIC INTERVENTION OR EXERCISE, SINGLE OR MULTIPLE DETERMINATIONS					
762	78455	VENOUS THROMBOSIS STUDY (EG, RADIOACTIVE FIBRINOGEN)					
762	78499	UNLISTED CARDIOVASCULAR PROCEDURE, DIAGNOSTIC NUCLEAR MEDICINE					
771	Standard	Planar Nuclear Medicine	S	3.78	$191.53	$116.84	$38.31
771	78006	THYROID IMAGING, WITH UPTAKE; SINGLE DETERMINATION					
771	78010	THYROID IMAGING; ONLY					
771	78011	THYROID IMAGING; WITH VASCULAR FLOW					
771	78015	THYROID CARCINOMA METASTASES IMAGING; LIMITED AREA (EG, NECK AND CHEST ONLY)					
771	78102	BONE MARROW IMAGING; LIMITED AREA					
771	78103	BONE MARROW IMAGING; MULTIPLE AREAS					
771	78104	BONE MARROW IMAGING; WHOLE BODY					
771	78185	SPLEEN IMAGING ONLY, WITH OR WITHOUT VASCULAR FLOW					
771	78201	LIVER IMAGING; STATIC ONLY					
771	78202	LIVER IMAGING; WITH VASCULAR FLOW					
771	78215	LIVER AND SPLEEN IMAGING; STATIC ONLY					
771	78216	LIVER AND SPLEEN IMAGING; WITH VASCULAR FLOW					
771	78230	SALIVARY GLAND IMAGING;					
771	78231	SALIVARY GLAND IMAGING; WITH SERIAL IMAGES					
771	78261	GASTRIC MUCOSA IMAGING					
771	78290	BOWEL IMAGING (EG, ECTOPIC GASTRIC MUCOSA, MECKEL'S LOCALIZATION, VOLVULUS)					
771	78300	BONE AND/OR JOINT IMAGING; LIMITED AREA					
771	78305	BONE AND/OR JOINT IMAGING; MULTIPLE AREAS					
771	78306	BONE AND/OR JOINT IMAGING; WHOLE BODY					

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
771	78399	UNLISTED MUSCULOSKELETAL PROCEDURE, DIAGNOSTIC NUCLEAR MEDICINE					
771	78428	CARDIAC SHUNT DETECTION					
771	78445	NON-CARDIAC VASCULAR FLOW IMAGING (IE, ANGIOGRAPHY, VENOGRAPHY)					
771	78457	VENOUS THROMBOSIS IMAGING (EG, VENOGRAM); UNILATERAL					
771	78458	VENOUS THROMBOSIS IMAGING (EG, VENOGRAM); BILATERAL					
771	78460	MYOCARDIAL PERFUSION IMAGING; (PLANAR) SINGLE STUDY, AT REST OR STRESS (EXERCISE AND/OR PHARMACOLOGIC), WITH OR WITHOUT QUANTIFICATION					
771	78466	MYOCARDIAL IMAGING, INFARCT AVID, PLANAR; QUALITATIVE OR QUANTITATIVE					
771	78478	MYOCARDIAL PERFUSION STUDY WITH WALL MOTION, QUALITATIVE OR QUANTITATIVE STUDY (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE) (USE ONLY FOR CODES 78460, 78461, 78464, 78465)					
771	78480	MYOCARDIAL PERFUSION STUDY WITH EJECTION FRACTION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE) (USE ONLY FOR CODES 78460, 78461, 78464, 78465)					
771	78481	CARDIAC BLOOD POOL IMAGING, (PLANAR), FIRST PASS TECHNIQUE; SINGLE STUDY, AT REST OR WITH STRESS (EXERCISE AND/OR PHARMACOLOGIC), WALL MOTION STUDY PLUS EJECTION FRACTION, WITH OR WITHOUT QUANTIFICATION					
771	78580	PULMONARY PERFUSION IMAGING, PARTICULATE					
771	78586	PULMONARY VENTILATION IMAGING, AEROSOL; SINGLE PROJECTION					
771	78587	PULMONARY VENTILATION IMAGING, AEROSOL; MULTIPLE PROJECTIONS (EG, ANTERIOR, POSTERIOR, LATERAL VIEWS)					
771	78591	PULMONARY VENTILATION IMAGING, GASEOUS, SINGLE BREATH, SINGLE PROJECTION					
771	78593	PULMONARY VENTILATION IMAGING, GASEOUS, WITH REBREATHING AND WASHOUT WITH OR WITHOUT SINGLE BREATH; SINGLE PROJECTION					
771	78599	UNLISTED RESPIRATORY PROCEDURE, DIAGNOSTIC NUCLEAR MEDICINE					
771	78600	BRAIN IMAGING, LIMITED PROCEDURE; STATIC					
771	78601	BRAIN IMAGING, LIMITED PROCEDURE; WITH VASCULAR FLOW					
771	78605	BRAIN IMAGING, COMPLETE STUDY; STATIC					
771	78610	BRAIN IMAGING, VASCULAR FLOW ONLY					
771	78660	RADIOPHARMACEUTICAL DACRYOCYSTOGRAPHY					
771	78699	UNLISTED NERVOUS SYSTEM PROCEDURE, DIAGNOSTIC NUCLEAR MEDICINE					
771	78700	KIDNEY IMAGING; STATIC ONLY					
771	78701	KIDNEY IMAGING; WITH VASCULAR FLOW					
771	78704	KIDNEY IMAGING; WITH FUNCTION STUDY (IE, IMAGING RENOGRAM)					
771	78707	KIDNEY IMAGING WITH VASCULAR FLOW AND FUNCTION; SINGLE STUDY WITHOUT PHARMACOLOGICAL INTERVENTION					
771	78715	KIDNEY VASCULAR FLOW ONLY					
771	78730	URINARY BLADDER RESIDUAL STUDY					
771	78760	TESTICULAR IMAGING;					
771	78761	TESTICULAR IMAGING; WITH VASCULAR FLOW					
771	78799	UNLISTED GENITOURINARY PROCEDURE, DIAGNOSTIC NUCLEAR MEDICINE					
772	Complex Planar Nuclear Medicine		S	4.22	$213.83	$127.92	$42.77
772	78007	THYROID IMAGING, WITH UPTAKE; MULTIPLE DETERMINATIONS					
772	78016	THYROID CARCINOMA METASTASES IMAGING; WITH ADDITIONAL STUDIES (EG, URINARY RECOVERY)					
772	78017	THYROID CARCINOMA METASTASES IMAGING; MULTIPLE AREAS					
772	78018	THYROID CARCINOMA METASTASES IMAGING; WHOLE BODY					
772	78070	PARATHYROID IMAGING					
772	78075	ADRENAL IMAGING, CORTEX AND/OR MEDULLA					
772	78195	LYMPHATICS AND LYMPH GLANDS IMAGING					
772	78220	LIVER FUNCTION STUDY WITH HEPATOBILIARY AGENTS, WITH SERIAL IMAGES					
772	78223	HEPATOBILIARY DUCTAL SYSTEM IMAGING, INCLUDING GALLBLADDER, WITH OR WITHOUT PHARMACOLOGIC INTERVENTION, WITH OR WITHOUT QUANTITATIVE MEASUREMENT OF GALLBLADDER FUNCTION					
772	78232	SALIVARY GLAND FUNCTION STUDY					
772	78258	ESOPHAGEAL MOTILITY					
772	78262	GASTROESOPHAGEAL REFLUX STUDY					
772	78264	GASTRIC EMPTYING STUDY					
772	78278	ACUTE GASTROINTESTINAL BLOOD LOSS IMAGING					
772	78291	PERITONEAL-VENOUS SHUNT PATENCY TEST (EG, FOR LEVEEN, DENVER SHUNT)					
772	78315	BONE AND/OR JOINT IMAGING; THREE PHASE STUDY					
772	78461	MYOCARDIAL PERFUSION IMAGING; MULTIPLE STUDIES, (PLANAR) AT REST AND/OR STRESS (EXERCISE AND/OR PHARMACOLOGIC), AND REDISTRIBUTION AND/OR REST INJECTION, WITH OR WITHOUT QUANTIFICATION					
772	78468	MYOCARDIAL IMAGING, INFARCT AVID, PLANAR; WITH EJECTION FRACTION BY FIRST PASS TECHNIQUE					
772	78472	CARDIAC BLOOD POOL IMAGING, GATED EQUILIBRIUM; SINGLE STUDY AT REST OR STRESS (EXERCISE AND/OR PHARMACOLOGIC), WALL MOTION STUDY PLUS EJECTION FRACTION, WITH OR WITHOUT ADDITIONAL QUANTITATIVE PROCESSING					
772	78473	MULTIPLE STUDIES, WALL MOTION STUDY PLUS EJECTION FRACTION, AT REST AND STRESS (EXERCISE AND/OR PHARMACOLOGIC), WITH OR WITHOUT ADDITIONAL QUANTIFICATION					
772	78483	CARDIAC BLOOD POOL IMAGING, (PLANAR), FIRST PASS TECHNIQUE; MULTIPLE STUDIES, AT REST AND WITH STRESS (EXERCISE AND/OR PHARMACOLOGIC), WALL MOTION STUDY PLUS EJECTION FRACTION, WITH OR WITHOUT QUANTIFICATION					
772	78584	PULMONARY PERFUSION IMAGING, PARTICULATE, WITH VENTILATION; SINGLE BREATH					
772	78585	PULMONARY PERFUSION IMAGING, PARTICULATE, WITH VENTILATION; REBREATHING AND WASHOUT, WITH OR WITHOUT SINGLE BREATH					
772	78594	PULMONARY VENTILATION IMAGING, GASEOUS, WITH REBREATHING AND WASHOUT WITH OR WITHOUT SINGLE BREATH; MULTIPLE PROJECTIONS (EG, ANTERIOR, POSTERIOR, LATERAL VIEWS)					
772	78596	PULMONARY QUANTITATIVE DIFFERENTIAL FUNCTION (VENTILATION/PERFUSION) STUDY					
772	78606	BRAIN IMAGING, COMPLETE STUDY; WITH VASCULAR FLOW					
772	78615	CEREBRAL BLOOD FLOW					
772	78630	CEREBROSPINAL FLUID FLOW, IMAGING (NOT INCLUDING INTRODUCTION OF MATERIAL); CISTERNOGRAPHY					
772	78635	CEREBROSPINAL FLUID FLOW, IMAGING (NOT INCLUDING INTRODUCTION OF MATERIAL); VENTRICULOGRAPHY					
772	78645	CEREBROSPINAL FLUID FLOW, IMAGING (NOT INCLUDING INTRODUCTION OF MATERIAL); SHUNT EVALUATION					
772	78650	CSF LEAKAGE DETECTION AND LOCALIZATION					

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
772	78708	KIDNEY IMAGING WITH VASCULAR FLOW AND FUNCTION; SINGLE STUDY, WITH PHARMACOLOGICAL INTERVENTION (EG, ANGIOTENSIN CONVERTING ENZYME INHIBITOR AND/OR DIURETIC)					
772	78709	KIDNEY IMAGING WITH VASCULAR FLOW AND FUNCTION; MULTIPLE STUDIES, WITH AND WITHOUT PHARMACOLOGICAL INTERVENTION (EG, ANGIOTENSIN CONVERTING ENZYME INHIBITOR AND/OR DIURETIC)					
772	78740	URETERAL REFLUX STUDY (RADIOPHARMACEUTICAL VOIDING CYSTOGRAM)					
772	78800	RADIOPHARMACEUTICAL LOCALIZATION OF TUMOR; LIMITED AREA					
772	78801	RADIOPHARMACEUTICAL LOCALIZATION OF TUMOR; MULTIPLE AREAS					
772	78802	RADIOPHARMACEUTICAL LOCALIZATION OF TUMOR; WHOLE BODY					
772	78805	RADIOPHARMACEUTICAL LOCALIZATION OF ABSCESS; LIMITED AREA					
772	78806	RADIOPHARMACEUTICAL LOCALIZATION OF ABSCESS; WHOLE BODY					
781	Standard SPECT Nuclear Medicine		S	5.26	$266.52	$145.77	$53.30
781	78205	LIVER IMAGING (SPECT)					
781	78320	BONE AND/OR JOINT IMAGING; TOMOGRAPHIC (SPECT)					
781	78464	MYOCARDIAL PERFUSION IMAGING; TOMOGRAPHIC (SPECT), SINGLE STUDY AT REST OR STRESS (EXERCISE AND/OR PHARMACOLOGIC), WITH OR WITHOUT QUANTIFICATION					
781	78469	MYOCARDIAL IMAGING, INFARCT AVID, PLANAR; TOMOGRAPHIC SPECT WITH OR WITHOUT QUANTIFICATION					
781	78607	BRAIN IMAGING, COMPLETE STUDY; TOMOGRAPHIC (SPECT)					
781	78647	CEREBROSPINAL FLUID FLOW, IMAGING (NOT INCLUDING INTRODUCTION OF MATERIAL); TOMOGRAPHIC (SPECT)					
781	78710	KIDNEY IMAGING, TOMOGRAPHIC (SPECT)					
782	Complex SPECT Nuclear Medicine		S	9.28	$470.21	$275.04	$94.04
782	78465	MYOCARDIAL PERFUSION IMAGING; TOMOGRAPHIC (SPECT), MULTIPLE STUDIES, AT REST AND/OR STRESS (EXERCISE AND/OR PHARMACOLOGIC) AND REDISTRIBUTION AND/OR REST INJECTION, WITH OR WITHOUT QUANTIFICATION					
782	78803	RADIOPHARMACEUTICAL LOCALIZATION OF TUMOR; TOMOGRAPHIC (SPECT)					
782	78807	RADIOPHARMACEUTICAL LOCALIZATION OF ABSCESS; TOMOGRAPHIC (SPECT)					
791	Standard Therapeutic Nuclear Medicine		S	15.83	$802.10	$562.06	$160.42
791	79001	RADIOPHARMACEUTICAL THERAPY, HYPERTHYROIDISM; SUBSEQUENT, EACH THERAPY					
791	79100	RADIOPHARMACEUTICAL THERAPY, POLYCYTHEMIA VERA, CHRONIC LEUKEMIA, EACH TREATMENT					
791	79300	INTERSTITIAL RADIOACTIVE COLLOID THERAPY					
791	79400	RADIOPHARMACEUTICAL THERAPY, NONTHYROID, NONHEMATOLOGIC					
791	79420	INTRAVASCULAR RADIOPHARMACEUTICAL THERAPY, PARTICULATE					
791	79440	INTRA-ARTICULAR RADIOPHARMACEUTICAL THERAPY					
791	79999	UNLISTED RADIOPHARMACEUTICAL THERAPEUTIC PROCEDURE					
792	Complex Therapeutic Nuclear Medicine		S	4.80	$243.21	$144.19	$48.64
792	79000	RADIOPHARMACEUTICAL THERAPY, HYPERTHYROIDISM; INITIAL, INCLUDING EVALUATION OF PATIENT					
792	79020	RADIOPHARMACEUTICAL THERAPY, THYROID SUPPRESSION (EUTHYROID CARDIAC DISEASE), INCLUDING EVALUATION OF PATIENT					
792	79030	RADIOPHARMACEUTICAL ABLATION OF GLAND FOR THYROID CARCINOMA					
792	79035	RADIOPHARMACEUTICAL THERAPY FOR METASTASES OF THYROID CARCINOMA					
792	79200	INTRACAVITARY RADIOACTIVE COLLOID THERAPY					
861	Immunology Tests		X	0.13	$6.59	$3.62	$1.32
861	86485	SKIN TEST; CANDIDA					
861	86490	SKIN TEST; COCCIDIOIDOMYCOSIS					
861	86510	SKIN TEST; HISTOPLASMOSIS					
861	86580	SKIN TEST; TUBERCULOSIS, INTRADERMAL					
861	86585	SKIN TEST; TUBERCULOSIS, TINE TEST					
861	86586	SKIN TEST; UNLISTED ANTIGEN, EACH					
881	Level I Pathology		X	0.20	$10.13	$6.78	$2.03
881	88125	CYTOPATHOLOGY, FORENSIC (EG, SPERM)					
881	88199	UNLISTED CYTOPATHOLOGY PROCEDURE					
881	88300	LEVEL I - SURGICAL PATHOLOGY, GROSS EXAMINATION ONLY					
881	88311	DECALCIFICATION PROCEDURE (LIST SEPARATELY IN ADDITION TO CODE FOR SURGICAL PATHOLOGY EXAMINATION)					
881	88313	SPECIAL STAINS (LIST SEPARATELY IN ADDITION TO CODE FOR SURGICAL PATHOLOGY EXAMINATION); GROUP II, ALL OTHER, (EG, IRON, TRICHROME), EXCEPT IMMUNOCYTOCHEMISTRY AND IMMUNOPEROXIDASE STAINS, EACH					
881	88399	UNLISTED SURGICAL PATHOLOGY PROCEDURE					
881	89350	SPUTUM, OBTAINING SPECIMEN, AEROSOL INDUCED TECHNIQUE (SEPARATE PROCEDURE)					
881	89360	SWEAT COLLECTION BY IONTOPHORESIS					
881	89399	UNLISTED MISCELLANEOUS PATHOLOGY TEST					
881	G0025	Collagen skin test kit					
882	Level II Pathology		X	0.39	$19.76	$11.75	$3.95
882	80500	CLINICAL PATHOLOGY CONSULTATION; LIMITED, WITHOUT REVIEW OF PATIENT'S HISTORY AND MEDICAL RECORDS					
882	80502	CLINICAL PATHOLOGY CONSULTATION; COMPREHENSIVE, FOR A COMPLEX DIAGNOSTIC PROBLEM, WITH REVIEW OF PATIENT'S HISTORY AND MEDICAL RECORDS					
882	85060	BLOOD SMEAR, PERIPHERAL, INTERPRETATION BY PHYSICIAN WITH WRITTEN REPORT					
882	85097	BONE MARROW; SMEAR INTERPRETATION ONLY, WITH OR WITHOUT DIFFERENTIAL CELL COUNT					
882	86077	BLOOD BANK PHYSICIAN SERVICES; DIFFICULT CROSS MATCH AND/OR EVALUATION OF IRREGULAR ANTIBODY(S), INTERPRETATION AND WRITTEN REPORT					
882	86078	BLOOD BANK PHYSICIAN SERVICES; INVESTIGATION OF TRANSFUSION REACTION INCLUDING SUSPICION OF TRANSMISSIBLE DISEASE, INTERPRETATION AND WRITTEN REPORT					
882	86079	BLOOD BANK PHYSICIAN SERVICES; AUTHORIZATION FOR DEVIATION FROM STANDARD BLOOD BANKING PROCEDURES (EG, USE OF OUTDATED BLOOD, TRANSFUSION OF RH INCOMPATIBLE UNITS), WITH WRITTEN REPORT					
882	88104	CYTOPATHOLOGY, FLUIDS, WASHINGS OR BRUSHINGS, EXCEPT CERVICAL OR VAGINAL; SMEARS WITH INTERPRETATION					

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
882	88106	CYTOPATHOLOGY, FLUIDS, WASHINGS OR BRUSHINGS, EXCEPT CERVICAL OR VAGINAL; FILTER METHOD ONLY WITH INTERPRETATION					
882	88107	CYTOPATHOLOGY, FLUIDS, WASHINGS OR BRUSHINGS, EXCEPT CERVICAL OR VAGINAL; SMEARS AND FILTER PREPARATION WITH INTERPRETATION					
882	88108	CYTOPATHOLOGY, CONCENTRATION TECHNIQUE, SMEARS AND INTERPRETATION (EG, SACCOMANNO TECHNIQUE)					
882	88160	CYTOPATHOLOGY, SMEARS, ANY OTHER SOURCE; SCREENING AND INTERPRETATION					
882	88161	CYTOPATHOLOGY, SMEARS, ANY OTHER SOURCE; PREPARATION, SCREENING AND INTERPRETATION					
882	88162	CYTOPATHOLOGY, SMEARS, ANY OTHER SOURCE; EXTENDED STUDY INVOLVING OVER 5 SLIDES AND/OR MULTIPLE STAINS					
882	88172	EVALUATION OF FINE NEEDLE ASPIRATE WITH OR WITHOUT PREPARATION OF SMEARS; IMMEDIATE CYTOHISTOLOGIC STUDY TO DETERMINE ADEQUACY OF SPECIMEN(S)					
882	88173	EVALUATION OF FINE NEEDLE ASPIRATE WITH OR WITHOUT PREPARATION OF SMEARS; INTERPRETATION AND REPORT					
882	88180	FLOW CYTOMETRY; EACH CELL SURFACE MARKER					
882	88182	FLOW CYTOMETRY; CELL CYCLE OR DNA ANALYSIS					
882	88302	LEVEL II - SURGICAL PATHOLOGY, GROSS AND MICROSCOPIC EXAMINATION					
882	88304	LEVEL III - SURGICAL PATHOLOGY, GROSS AND MICROSCOPIC EXAMINATION					
882	88305	LEVEL IV - SURGICAL PATHOLOGY, GROSS AND MICROSCOPIC EXAMINATION					
882	88312	SPECIAL STAINS (LIST SEPARATELY IN ADDITION TO CODE FOR SURGICAL PATHOLOGY EXAMINATION); GROUP I FOR MICROORGANISMS (EG, GRIDLEY, ACID FAST, METHENAMINE SILVER), EACH					
882	88314	SPECIAL STAINS (LIST SEPARATELY IN ADDITION TO CODE FOR SURGICAL PATHOLOGY EXAMINATION); HISTOCHEMICAL STAINING WITH FROZEN SECTION(S)					
882	88318	DETERMINATIVE HISTOCHEMISTRY TO IDENTIFY CHEMICAL COMPONENTS (EG, COPPER, ZINC)					
882	88319	DETERMINATIVE HISTOCHEMISTRY OR CYTOCHEMISTRY TO IDENTIFY ENZYME CONSTITUENTS, EACH					
882	88321	CONSULTATION AND REPORT ON REFERRED SLIDES PREPARED ELSEWHERE					
882	88323	CONSULTATION AND REPORT ON REFERRED MATERIAL REQUIRING PREPARATION OF SLIDES					
882	88325	CONSULTATION, COMPREHENSIVE, WITH REVIEW OF RECORDS AND SPECIMENS, WITH REPORT ON REFERRED MATERIAL					
882	88329	PATHOLOGY CONSULTATION DURING SURGERY;					
882	88331	PATHOLOGY CONSULTATION DURING SURGERY; WITH FROZEN SECTION(S), SINGLE SPECIMEN					
882	88332	PATHOLOGY CONSULTATION DURING SURGERY; EACH ADDITIONAL TISSUE BLOCK WITH FROZEN SECTION(S)					
882	88342	IMMUNOCYTOCHEMISTRY (INCLUDING TISSUE IMMUNOPEROXIDASE), EACH ANTIBODY					
882	88346	IMMUNOFLUORESCENT STUDY, EACH ANTIBODY; DIRECT METHOD					
882	88347	IMMUNOFLUORESCENT STUDY, EACH ANTIBODY; INDIRECT METHOD					
883	Level III Pathology		X	0.65	$32.94	$20.34	$6.59
883	88307	LEVEL V - SURGICAL PATHOLOGY, GROSS AND MICROSCOPIC EXAMINATION					
883	88309	LEVEL VI - SURGICAL PATHOLOGY, GROSS AND MICROSCOPIC EXAMINATION					
883	88348	ELECTRON MICROSCOPY; DIAGNOSTIC					
883	88349	ELECTRON MICROSCOPY; SCANNING					
883	88355	MORPHOMETRIC ANALYSIS; SKELETAL MUSCLE					
883	88356	MORPHOMETRIC ANALYSIS; NERVE					
883	88358	MORPHOMETRIC ANALYSIS; TUMOR					
883	88362	NERVE TEASING PREPARATIONS					
883	88365	TISSUE IN SITU HYBRIDIZATION, INTERPRETATION AND REPORT					
900	Critical Care		V	7.44	$376.98	$144.87	$75.40
900	99291	CRITICAL CARE, EVALUATION AND MANAGEMENT OF THE UNSTABLE CRITICALLY ILL OR UNSTABLE CRITICALLY INJURED PATIENT, REQUIRING THE CONSTANT ATTENDANCE OF THE PHYSICIAN; FIRST HOUR					
901	Level I Immunization		X	0.07	$3.55	$2.49	$0.71
901	90700	IMMUNIZATION, ACTIVE; DIPHTHERIA, TETANUS TOXOIDS, AND ACELLULAR PERTUSSIS VACCINE (DTAP)					
901	90701	IMMUNIZATION, ACTIVE; DIPHTHERIA AND TETANUS TOXOIDS AND PERTUSSIS VACCINE (DTP)					
901	90702	IMMUNIZATION, ACTIVE; DIPHTHERIA AND TETANUS TOXOIDS (DT)					
901	90703	IMMUNIZATION, ACTIVE; TETANUS TOXOID					
901	90704	IMMUNIZATION, ACTIVE; MUMPS VIRUS VACCINE, LIVE					
901	90705	IMMUNIZATION, ACTIVE; MEASLES VIRUS VACCINE, LIVE, ATTENUATED					
901	90706	IMMUNIZATION, ACTIVE; RUBELLA VIRUS VACCINE, LIVE					
901	90708	IMMUNIZATION, ACTIVE; MEASLES AND RUBELLA VIRUS VACCINE, LIVE					
901	90709	IMMUNIZATION, ACTIVE; RUBELLA AND MUMPS VIRUS VACCINE, LIVE					
901	90710	IMMUNIZATION, ACTIVE; MEASLES, MUMPS, RUBELLA, AND VARICELLA VACCINE					
901	90711	IMMUNIZATION, ACTIVE; DIPHTHERIA, TETANUS TOXOIDS, AND PERTUSSIS (DTP) AND INJECTABLE POLIOMYELITIS VACCINE					
901	90714	IMMUNIZATION, ACTIVE; TYPHOID VACCINE					
901	90718	IMMUNIZATION, ACTIVE; TETANUS AND DIPHTHERIA TOXOIDS ABSORBED, FOR ADULT USE (TD)					
901	90719	IMMUNIZATION, ACTIVE; DIPHTHERIA TOXOID					
901	90724	IMMUNIZATION, ACTIVE; INFLUENZA VIRUS VACCINE					
901	90725	IMMUNIZATION, ACTIVE; CHOLERA VACCINE					
901	90730	IMMUNIZATION, ACTIVE; HEPATITIS A VACCINE					
901	90732	IMMUNIZATION, ACTIVE; PNEUMOCOCCAL VACCINE, POLYVALENT					
901	90748	IMMUNIZATION, ACTIVE, HEPATITIS B AND HEMOPHILUS INFLUENZA B (HIB) VACCINE					
901	90749	UNLISTED IMMUNIZATION PROCEDURE					
901	95149	PROFESSIONAL SERVICES FOR THE SUPERVISION AND PROVISION OF ANTIGENS FOR ALLERGEN IMMUNOTHERAPY (SPECIFY NUMBER OF DOSES); FIVE SINGLE STINGING INSECT VENOMS					
901	95170	PROFESSIONAL SERVICES FOR THE SUPERVISION AND PROVISION OF ANTIGENS FOR ALLERGEN IMMUNOTHERAPY; WHOLE BODY EXTRACT OF BITING INSECT OR OTHER ARTHROPOD (SPECIFY NUMBER OF DOSES)					
901	G0008	INFLUENZA VACCINE					
901	G0009	PNEUMOCOCCAL VACCINE					
901	Q0034	INFLUENZA VACCINE					
902	Level II Immunization		X	1.78	$90.19	$41.47	$18.04

(See Addendum D. for Payment of Medical Visits)

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
902	90707	IMMUNIZATION, ACTIVE; MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE					
902	90712	IMMUNIZATION, ACTIVE; POLIOVIRUS VACCINE, LIVE, ORAL (ANY TYPE(S))					
902	90713	IMMUNIZATION, ACTIVE; POLIOMYELITIS VACCINE					
902	90716	IMMUNIZATION, ACTIVE; VARICELLA (CHICKEN POX) VACCINE					
902	90717	IMMUNIZATION, ACTIVE; YELLOW FEVER VACCINE					
902	90720	IMMUNIZATION, ACTIVE; DIPHTHERIA, TETANUS TOXOIDS, AND PERTUSSIS (DTP) AND HEMOPHILUS INFLUENZA B (HIB) VACCINE					
902	90733	IMMUNIZATION, ACTIVE; MENINGOCOCCAL POLYSACCHARIDE VACCINE (ANY GROUP(S))					
902	90737	IMMUNIZATION, ACTIVE; HEMOPHILUS INFLUENZA B					
902	90741	IMMUNIZATION, PASSIVE; IMMUNE SERUM GLOBULIN, HUMAN (ISG)					
902	90744	IMMUNIZATION, ACTIVE, HEPATITIS B VACCINE; NEWBORN TO 11 YEARS					
902	90745	IMMUNIZATION, ACTIVE, HEPATITIS B VACCINE; 11–19 YEARS					
902	90746	IMMUNIZATION, ACTIVE, HEPATITIS B VACCINE; 20 YEARS AND ABOVE					
902	90747	IMMUNIZATION, ACTIVE, HEPATITIS B VACCINE; DIALYSIS OR IMMUNOSUPPRESSED PATIENT, ANY AGE					
902	G0010	HEPATITIS B VACCINE					
903	Level III Immunization		X	1.16	$58.78	$25.65	$11.76
903	90721	IMMUNIZATION, ACTIVE; DIPHTHERIA, TETANUS TOXOIDS, AND ACELLULAR PERTUSSIS VACCINE (DTAP) AND HEMOPHILUS INFLUENZA B (HIB) VACCINE					
903	90726	IMMUNIZATION, ACTIVE; RABIES VACCINE					
903	90727	IMMUNIZATION, ACTIVE; PLAGUE VACCINE					
903	90728	IMMUNIZATION, ACTIVE; BCG VACCINE					
903	90735	IMMUNIZATION, ACTIVE; ENCEPHALITIS VIRUS VACCINE					
903	90742	IMMUNIZATION, PASSIVE; SPECIFIC HYPERIMMUNE SERUM GLOBULIN (EG, HEPATITIS B, MEASLES, PERTUSSIS, RABIES, RHO(D), TETANUS, VACCINIA, VARICELLA-ZOSTER)					
906	Infusion Therapy except Chemotherapy		X	1.46	$73.98	$42.49	$14.80
906	36680	PLACEMENT OF NEEDLE FOR INTRAOSSEOUS INFUSION					
906	90780	IV INFUSION FOR THERAPY/DIAGNOSIS, ADMINISTERED BY PHYSICIAN OR UNDER DIRECT SUPERVISION OF PHYSICIAN; UP TO ONE HOUR					
906	90781	IV INFUSION FOR THERAPY/DIAGNOSIS, ADMINISTERED BY PHYSICIAN OR UNDER DIRECT SUPERVISION OF PHYSICIAN; EACH ADDITIONAL HOUR, UP TO EIGHT (8) HOURS					
906	Q0081	INFUSION THERAPY					
907	Intramuscular Injections		X	0.85	$43.07	$11.98	$8.61
907	90782	THERAPEUTIC OR DIAGNOSTIC INJECTION (SPECIFY MATERIAL INJECTED); SUBCUTANEOUS OR INTRAMUSCULAR					
907	90783	THERAPEUTIC OR DIAGNOSTIC INJECTION (SPECIFY MATERIAL INJECTED); INTRA-ARTERIAL					
907	90784	THERAPEUTIC OR DIAGNOSTIC INJECTION (SPECIFY MATERIAL INJECTED); INTRAVENOUS					
907	90788	INTRAMUSCULAR INJECTION OF ANTIBIOTIC (SPECIFY)					
907	90799	UNLISTED THERAPEUTIC OR DIAGNOSTIC INJECTION					
919	Electroconvulsive Therapy		S	3.17	$160.62	$80.00	$32.12
919	90870	ELECTROCONVULSIVE THERAPY (INCLUDES NECESSARY MONITORING); SINGLE SEIZURE					
919	90871	ELECTROCONVULSIVE THERAPY (INCLUDES NECESSARY MONITORING); MULTIPLE SEIZURES, PER DAY					
920	Biofeedback and other Training		S	1.17	$59.28	$29.61	$11.86
920	90901	BIOFEEDBACK TRAINING BY ANY MODALITY					
920	90911	BIOFEEDBACK TRAINING, PERINEAL MUSCLES, ANORECTAL OR URETHRAL SPHINCTER, INCLUDING EMG AND/OR MANOMETRY					
921	Diabetes Education		S				
921	99078	PHYSICIAN EDUCATIONAL SERVICES RENDERED TO PATIENTS IN A GROUP SETTING (EG, PRENATAL, OBESITY, OR DIABETIC INSTRUCTIONS)					
926	Dialysis for other than ESRD patients		S	4.28	$216.87	$69.83	$43.37
926	90935	HEMODIALYSIS PROCEDURE WITH SINGLE PHYSICIAN EVALUATION					
926	90937	HEMODIALYSIS PROCEDURE REQUIRING REPEATED EVALUATION(S) WITH OR WITHOUT SUBSTANTIAL REVISION OF DIALYSIS PRESCRIPTION					
926	90945	DIALYSIS PROCEDURE OTHER THAN HEMODIALYSIS (EG, PERITONEAL, HEMOFILTRATION), WITH SINGLE PHYSICIAN EVALUATION					
926	90947	DIALYSIS PROCEDURE OTHER THAN HEMODIALYSIS (EG, PERITONEAL, HEMOFILTRATION) REQUIRING REPEATED EVALUATIONS, WITH OR WITHOUT SUBSTANTIAL REVISION OF DIALYSIS PRESCRIPTION					
926	90997	HEMOPERFUSION (EG, WITH ACTIVATED CHARCOAL OR RESIN)					
926	90999	UNLISTED DIALYSIS PROCEDURE, INPATIENT OR OUTPATIENT					
928	Alimentary Tests		X	3.11	$157.58	$83.85	$31.52
928	89100	DUODENAL INTUBATION AND ASPIRATION; SINGLE SPECIMEN (EG, SIMPLE BILE STUDY OR AFFERENT LOOP CULTURE) PLUS APPROPRIATE TEST PROCEDURE					
928	89105	DUODENAL INTUBATION AND ASPIRATION; COLLECTION OF MULTIPLE FRACTIONAL SPECIMENS WITH PANCREATIC OR GALLBLADDER STIMULATION, SINGLE OR DOUBLE LUMEN TUBE					
928	89130	GASTRIC INTUBATION AND ASPIRATION, DIAGNOSTIC, EACH SPECIMEN, FOR CHEMICAL ANALYSES OR CYTOPATHOLOGY;					
928	89132	GASTRIC INTUBATION AND ASPIRATION, DIAGNOSTIC, EACH SPECIMEN, AFTER STIMULATION					
928	89135	GASTRIC INTUBATION, ASPIRATION, AND FRACTIONAL COLLECTIONS (EG, GASTRIC SECRETORY STUDY); ONE HOUR					
928	89136	GASTRIC INTUBATION, ASPIRATION, AND FRACTIONAL COLLECTIONS (EG, GASTRIC SECRETORY STUDY); TWO HOURS					
928	89140	GASTRIC INTUBATION, ASPIRATION, AND FRACTIONAL COLLECTIONS (EG, GASTRIC SECRETORY STUDY); TWO HOURS INCLUDING GASTRIC STIMULATION (EG, HISTALOG, PENTAGASTRIN)					
928	89141	GASTRIC INTUBATION, ASPIRATION, AND FRACTIONAL COLLECTIONS (EG, GASTRIC SECRETORY STUDY); THREE HOURS, INCLUDING GASTRIC STIMULATION					
928	91000	ESOPHAGEAL INTUBATION AND COLLECTION OF WASHINGS FOR CYTOLOGY, INCLUDING PREPARATION OF SPECIMENS (SEPARATE PROCEDURE)					
928	91010	ESOPHAGEAL MOTILITY (MANOMETRIC STUDY OF THE ESOPHAGUS AND/OR GASTROESOPHAGEAL JUNCTION) STUDY;					

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
928	91011	ESOPHAGEAL MOTILITY (MANOMETRIC STUDY OF THE ESOPHAGUS AND/OR GASTROESOPHAGEAL JUNCTION) STUDY; WITH MECHOLYL OR SIMILAR STIMULANT					
928	91012	ESOPHAGEAL MOTILITY (MANOMETRIC STUDY OF THE ESOPHAGUS AND/OR GASTROESOPHAGEAL JUNCTION) STUDY; WITH ACID PERFUSION STUDIES					
928	91020	GASTRIC MOTILITY (MANOMETRIC) STUDIES					
928	91030	ESOPHAGUS, ACID PERFUSION (BERNSTEIN) TEST FOR ESOPHAGITIS					
928	91032	ESOPHAGUS, ACID REFLUX TEST, WITH INTRALUMINAL PH ELECTRODE FOR DETECTION OF GASTROESOPHAGEAL REFLUX;					
928	91033	ESOPHAGUS, ACID REFLUX TEST, WITH INTRALUMINAL PH ELECTRODE FOR DETECTION OF GASTROESOPHAGEAL REFLUX; PROLONGED RECORDING					
928	91052	GASTRIC ANALYSIS TEST WITH INJECTION OF STIMULANT OF GASTRIC SECRETION (EG, HISTAMINE, INSULIN, PENTAGASTRIN, CALCIUM AND SECRETIN)					
928	91055	GASTRIC INTUBATION, WASHINGS, AND PREPARING SLIDES FOR CYTOLOGY (SEPARATE PROCEDURE)					
928	91060	GASTRIC SALINE LOAD TEST					
928	91065	BREATH HYDROGEN TEST (EG, FOR DETECTION OF LACTASE DEFICIENCY)					
928	91100	INTESTINAL BLEEDING TUBE, PASSAGE, POSITIONING AND MONITORING					
928	91105	GASTRIC INTUBATION, AND ASPIRATION OR LAVAGE FOR TREATMENT (EG, FOR INGESTED POISONS)					
928	91299	UNLISTED DIAGNOSTIC GASTROENTEROLOGY PROCEDURE					
928	95075	INGESTION CHALLENGE TEST (SEQUENTIAL AND INCREMENTAL INGESTION OF TEST ITEMS, EG, FOOD, DRUG OR OTHER SUBSTANCE SUCH AS METABISULFITE)					
930	Minor Eye Examinations		X	1.02	$51.68	$22.83	$10.34
930	92060	SENSORIMOTOR EXAMINATION WITH MULTIPLE MEASUREMENTS OF OCULAR DEVIATION (EG, RESTRICTIVE OR PARETIC MUSCLE WITH DIPLOPIA) WITH INTERPRETATION AND REPORT (SEPARATE PROCEDURE)					
930	92065	ORTHOPTIC AND/OR PLEOPTIC TRAINING, WITH CONTINUING MEDICAL DIRECTION AND EVALUATION					
930	92081	VISUAL FIELD EXAMINATION, UNILATERAL OR BILATERAL, WITH INTERPRETATION AND REPORT; LIMITED EXAMINATION (EG, TANGENT SCREEN, AUTOPLOT, ARC PERIMETER, OR SINGLE STIMULUS LEVEL AUTOMATED TEST, SUCH AS OCTOPUS 3 OR 7 EQUIVALENT)					
930	92082	VISUAL FIELD EXAMINATION, UNILATERAL OR BILATERAL, WITH INTERPRETATION AND REPORT; INTERMEDIATE EXAMINATION (EG, AT LEAST 2 ISOPTERS ON GOLDMANN PERIMETER, OR SEMIQUANTITATIVE, AUTOMATED SUPRATHRESHOLD SCREENING PROGRAM, HUMPHREY SUPRATHRESHOLD AUTOMATIC					
930	92083	VISUAL FIELD EXAMINATION, UNILATERAL OR BILATERAL, WITH INTERPRETATION AND REPORT; EXTENDED EXAMINATION (EG, GOLDMANN VISUAL FIELDS WITH AT LEAST 3 ISOPTERS PLOTTED AND STATIC DETERMINATION WITHIN THE CENTRAL 30!, OR QUANTITATIVE, AUTOMATED THRESHOLD PERI					
930	92140	PROVOCATIVE TESTS FOR GLAUCOMA, WITH INTERPRETATION AND REPORT, WITHOUT TONOGRAPHY					
930	92283	COLOR VISION EXAMINATION, EXTENDED, EG, ANOMALOSCOPE OR EQUIVALENT					
930	92284	DARK ADAPTATION EXAMINATION WITH INTERPRETATION AND REPORT					
930	92285	EXTERNAL OCULAR PHOTOGRAPHY WITH INTERPRETATION AND REPORT FOR DOCUMENTATION OF MEDICAL PROGRESS (EG, CLOSE-UP PHOTOGRAPHY, SLIT LAMP PHOTOGRAPHY, GONIOPHOTOGRAPHY, STEREO-PHOTOGRAPHY)					
931	Level I Eye Tests		X	0.74	$37.5	$21.47	$7.50
931	92120	TONOGRAPHY WITH INTERPRETATION AND REPORT, RECORDING INDENTATION TONOMETER METHOD OR PERILIMBAL SUCTION METHOD					
931	92130	TONOGRAPHY WITH WATER PROVOCATION					
931	92230	FLUORESCEIN ANGIOSCOPY WITH INTERPRETATION AND REPORT					
931	92240	INDOCYANINE-GREEN ANGIOGRAPHY (INCLUDES MULTIFRAME IMAGING) WITH INTERPRETATION AND REPORT					
931	92250	FUNDUS PHOTOGRAPHY WITH INTERPRETATION AND REPORT					
931	92499	UNLISTED OPHTHALMOLOGICAL SERVICE OR PROCEDURE					
932	Level II Eye Tests		X	2.52	$127.69	$65.09	$25.54
932	92235	FLUORESCEIN ANGIOGRAPHY (INCLUDES MULTIFRAME IMAGING) WITH INTERPRETATION AND REPORT					
932	92265	NEEDLE OCULOELECTROMYOGRAPHY, ONE OR MORE EXTRAOCULAR MUSCLES, ONE OR BOTH EYES, WITH INTERPRETATION AND REPORT					
932	92270	ELECTRO-OCULOGRAPHY WITH INTERPRETATION AND REPORT					
932	92286	SPECIAL ANTERIOR SEGMENT PHOTOGRAPHY WITH INTERPRETATION AND REPORT; WITH SPECULAR ENDOTHELIAL MICROSCOPY AND CELL COUNT					
932	92287	SPECIAL ANTERIOR SEGMENT PHOTOGRAPHY WITH INTERPRETATION AND REPORT; WITH FLUORESCEIN ANGIOGRAPHY					
936	Fitting of Vision Aids		X	0.52	$26.35	$9.49	$5.27
936	92311	PRESCRIPTION OF OPTICAL AND PHYSICAL CHARACTERISTICS OF AND FITTING OF CONTACT LENS, WITH MEDICAL SUPERVISION OF ADAPTATION; CORNEAL LENS FOR APHAKIA, ONE EYE					
936	92312	PRESCRIPTION OF OPTICAL AND PHYSICAL CHARACTERISTICS OF AND FITTING OF CONTACT LENS, WITH MEDICAL SUPERVISION OF ADAPTATION; CORNEAL LENS FOR APHAKIA, BOTH EYES					
936	92313	PRESCRIPTION OF OPTICAL AND PHYSICAL CHARACTERISTICS OF AND FITTING OF CONTACT LENS, WITH MEDICAL SUPERVISION OF ADAPTATION; CORNEOSCLERAL LENS					
936	92315	PRESCRIPTION OF OPTICAL AND PHYSICAL CHARACTERISTICS OF CONTACT LENS, WITH MEDICAL SUPERVISION OF ADAPTATION AND DIRECTION OF FITTING BY INDEPENDENT TECHNICIAN; CORNEAL LENS FOR APHAKIA, ONE EYE					
936	92316	PRESCRIPTION OF OPTICAL AND PHYSICAL CHARACTERISTICS OF CONTACT LENS, WITH MEDICAL SUPERVISION OF ADAPTATION AND DIRECTION OF FITTING BY INDEPENDENT TECHNICIAN; CORNEAL LENS FOR APHAKIA, BOTH EYES					
936	92317	PRESCRIPTION OF OPTICAL AND PHYSICAL CHARACTERISTICS OF CONTACT LENS, WITH MEDICAL SUPERVISION OF ADAPTATION AND DIRECTION OF FITTING BY INDEPENDENT TECHNICIAN; CORNEOSCLERAL LENS					
936	92325	MODIFICATION OF CONTACT LENS (SEPARATE PROCEDURE), WITH MEDICAL SUPERVISION OF ADAPTATION					
936	92326	REPLACEMENT OF CONTACT LENS					
936	92330	PRESCRIPTION, FITTING, AND SUPPLY OF OCULAR PROSTHESIS (ARTIFICIAL EYE), WITH MEDICAL SUPERVISION OF ADAPTATION					
936	92352	FITTING OF SPECTACLE PROSTHESIS FOR APHAKIA; MONOFOCAL					
936	92353	FITTING OF SPECTACLE PROSTHESIS FOR APHAKIA; MULTIFOCAL					
936	92354	FITTING OF SPECTACLE MOUNTED LOW VISION AID; SINGLE ELEMENT SYSTEM					
936	92355	FITTING OF SPECTACLE MOUNTED LOW VISION AID; TELESCOPIC OR OTHER COMPOUND LENS SYSTEM					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
936	92358	PROSTHESIS SERVICE FOR APHAKIA, TEMPORARY (DISPOSABLE OR LOAN, INCLUDING MATERIALS)					
936	92371	REPAIR AND REFITTING SPECTACLES; SPECTACLE PROSTHESIS FOR APHAKIA					
940		Otorhinolaryngologic Function Tests	X	3.04	$154.04	$51.98	$30.81
940	92512	NASAL FUNCTION STUDIES (EG, RHINOMANOMETRY)					
940	92516	FACIAL NERVE FUNCTION STUDIES (EG, ELECTRONEURONOGRAPHY)					
940	92520	LARYNGEAL FUNCTION STUDIES					
940	92541	SPONTANEOUS NYSTAGMUS TEST, INCLUDING GAZE AND FIXATION NYSTAGMUS, WITH RECORDING					
940	92542	POSITIONAL NYSTAGMUS TEST, MINIMUM OF 4 POSITIONS, WITH RECORDING					
940	92543	CALORIC VESTIBULAR TEST, EACH IRRIGATION (BINAURAL, BITHERMAL STIMULATION CONSTITUTES FOUR TESTS), WITH					
940	92544	OPTOKINETIC NYSTAGMUS TEST, BIDIRECTIONAL, FOVEAL OR PERIPHERAL STIMULATION, WITH RECORDING					
940	92545	OSCILLATING TRACKING TEST, WITH RECORDING					
940	92546	SINUSOIDAL VERTICAL AXIS ROTATIONAL TESTING					
940	92547	USE OF VERTICAL ELECTRODES IN ANY OR ALL OF ABOVE TESTS COUNTS AS ONE ADDITIONAL TEST					
940	92548	COMPUTERIZED DYNAMIC POSTUROGRAPHY					
940	92584	ELECTROCOCHLEOGRAPHY					
940	92587	EVOKED OTOACOUSTIC EMISSIONS; LIMITED (SINGLE STIMULUS LEVEL, EITHER TRANSIENT OR DISTORTION PRODUCTS)					
940	92588	EVOKED OTOACOUSTIC EMISSIONS; COMPREHENSIVE OR DIAGNOSTIC EVALUATION (COMPARISON OF TRANSIENT AND/OR DISTORTION PRODUCT OTOACOUSTIC EMISSIONS AT MULTIPLE LEVELS AND FREQUENCIES)					
941		Level I Audiometry	X	0.74	$37.50	$13.56	$7.50
941	92552	PURE TONE AUDIOMETRY (THRESHOLD); AIR ONLY					
941	92553	PURE TONE AUDIOMETRY (THRESHOLD); AIR AND BONE					
941	92555	SPEECH AUDIOMETRY THRESHOLD;					
941	92556	SPEECH AUDIOMETRY THRESHOLD; WITH SPEECH RECOGNITION					
941	92567	TYMPANOMETRY (IMPEDANCE TESTING)					
941	92599	UNLISTED OTORHINOLARYNGOLOGICAL SERVICE OR PROCEDURE					
942		Level II Audiometry	X	1.48	$74.99	$22.15	$15.00
942	92557	COMPREHENSIVE AUDIOMETRY THRESHOLD EVALUATION AND SPEECH RECOGNITION (92553 AND 92556 COMBINED)					
942	92561	BEKESY AUDIOMETRY; DIAGNOSTIC					
942	92562	LOUDNESS BALANCE TEST, ALTERNATE BINAURAL OR MONAURAL					
942	92563	TONE DECAY TEST					
942	92564	SHORT INCREMENT SENSITIVITY INDEX (SISI)					
942	92565	STENGER TEST, PURE TONE					
942	92568	ACOUSTIC REFLEX TESTING					
942	92569	ACOUSTIC REFLEX DECAY TEST					
942	92571	FILTERED SPEECH TEST					
942	92572	STAGGERED SPONDAIC WORD TEST					
942	92573	LOMBARD TEST					
942	92575	SENSORINEURAL ACUITY LEVEL TEST					
942	92576	SYNTHETIC SENTENCE IDENTIFICATION TEST					
942	92577	STENGER TEST, SPEECH					
942	92579	VISUAL REINFORCEMENT AUDIOMETRY (VRA)					
942	92582	CONDITIONING PLAY AUDIOMETRY					
942	92583	SELECT PICTURE AUDIOMETRY					
942	92589	CENTRAL AUDITORY FUNCTION TEST(S) (SPECIFY)					
942	92596	EAR PROTECTOR ATTENUATION MEASUREMENTS					
947		Resuscitation and Cardioversion	S	4.07	$206.22	$109.61	$41.24
947	31500	INTUBATION, ENDOTRACHEAL, EMERGENCY PROCEDURE					
947	92950	CARDIOPULMONARY RESUSCITATION (EG, IN CARDIAC ARREST)					
947	92953	TEMPORARY TRANSCUTANEOUS PACING					
947	92960	CARDIOVERSION, ELECTIVE, ELECTRICAL CONVERSION OF ARRHYTHMIA, EXTERNAL					
947	99440	NEWBORN RESUSCITATION: PROVISION OF POSITIVE PRESSURE VENTILATION AND/OR CHEST COMPRESSIONS IN THE PRESENCE OF ACUTE INADEQUATE VENTILATION AND/OR CARDIAC OUTPUT					
948		Cardiac Rehabilitation	X	0.81	$41.04	$16.95	$8.21
948	93797	PHYSICIAN SERVICES FOR OUTPATIENT CARDIAC REHABILITATION; WITHOUT CONTINUOUS ECG MONITORING (PER SESSION)					
948	93798	PHYSICIAN SERVICES FOR OUTPATIENT CARDIAC REHABILITATION; WITH CONTINUOUS ECG MONITORING (PER SESSION)					
949		Cardiovascular Stress Test	X	1.46	$73.98	$62.83	$14.80
949	93017	CARDIOVASCULAR STRESS TEST USING MAXIMAL OR SUBMAXIMAL TREADMILL OR BICYCLE EXERCISE, CONTINOUS ELECTROCARDIOGRAPHIC MONITORING, AND/OR PHARMACOLOGICAL STRESS; TRACING ONLY, WITHOUT INTERPRETATION AND REPORT					
949	93024	ERGONOVINE PROVOCATION TEST					
950		Electrocardiogram (ECG)	X	0.35	$17.73	$15.82	$3.55
950	93005	ELECTROCARDIOGRAM, ROUTINE ECG WITH AT LEAST 12 LEADS; TRACING ONLY, WITHOUT INTERPRETATION AND REPORT					
950	93041	RHYTHM ECG, ONE TO THREE LEADS; TRACING ONLY WITHOUT INTERPRETATION AND REPORT					
950	Q0035	CARDIOKYMOGRAPHY					
956		Continuous ECG and Blood Pressure Monitoring	X	1.11	$56.24	$55.82	$11.25
956	93012	TELEPHONIC TRANSMISSION OF POST-SYMPTOM ELECTROCARDIOGRAM RHYTHM STRIP(S), PER 30 DAY PERIOD OF TIME; TRACING ONLY					
956	93224	ELECTROCARDIOGRAPHIC MONITORING FOR 24 HOURS BY CONTINUOUS ORIGINAL ECG WAVEFORM RECORDING AND STORAGE, WITH VISUAL SUPERIMPOSITION SCANNING; INCLUDES RECORDING, SCANNING ANALYSIS WITH REPORT, PHYSICIAN REVIEW AND INTERPRETATION					

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
956	93225	ELECTROCARDIOGRAPHIC MONITORING FOR 24 HOURS BY CONTINUOUS ORIGINAL ECG WAVEFORM RECORDING AND STORAGE, WITH VISUAL SUPERIMPOSITION SCANNING; RECORDING (INCLUDES HOOK-UP, RECORDING, AND DISCONNECTION)					
956	93226	ELECTROCARDIOGRAPHIC MONITORING FOR 24 HOURS BY CONTINUOUS ORIGINAL ECG WAVEFORM RECORDING AND STORAGE, WITH VISUAL SUPERIMPOSITION SCANNING; SCANNING ANALYSIS WITH REPORT					
956	93230	ELECTROCARDIOGRAPHIC MONITORING FOR 24 HOURS BY CONTINUOUS ORIGINAL ECG WAVEFORM RECORDING AND STORAGE WITHOUT SUPERIMPOSITION SCANNING UTILIZING A DEVICE CAPABLE OF PRODUCING A FULL MINIATURIZED PRINTOUT; INCLUDES RECORDING, MICROPROCESSOR-BASED ANALYSIS					
956	93231	ELECTROCARDIOGRAPHIC MONITORING FOR 24 HOURS BY CONTINUOUS ORIGINAL ECG WAVEFORM RECORDING AND STORAGE WITHOUT SUPERIMPOSITION SCANNING UTILIZING A DEVICE CAPABLE OF PRODUCING A FULL MINIATURIZED PRINTOUT; RECORDING (INCLUDES HOOK-UP, RECORDING, AND DISCO					
956	93232	ELECTROCARDIOGRAPHIC MONITORING FOR 24 HOURS BY CONTINUOUS ORIGINAL ECG WAVEFORM RECORDING AND STORAGE WITHOUT SUPERIMPOSITION SCANNING UTILIZING A DEVICE CAPABLE OF PRODUCING A FULL MINIATURIZED PRINTOUT; MICROPROCESSOR-BASED ANALYSIS WITH REPORT					
956	93235	ELECTROCARDIOGRAPHIC MONITORING FOR 24 HOURS BY CONTINUOUS COMPUTERIZED MONITORING AND NON-CONTINUOUS RECORDING, AND REAL-TIME DATA ANALYSIS UTILIZING A DEVICE CAPABLE OF PRODUCING INTERMITTENT FULL-SIZED WAVEFORM TRACINGS, POSSIBLY PATIENT ACTIVATED; INC					
956	93236	ELECTROCARDIOGRAPHIC MONITORING FOR 24 HOURS BY CONTINUOUS COMPUTERIZED MONITORING AND NON-CONTINUOUS RECORDING, AND REAL-TIME DATA ANALYSIS UTILIZING A DEVICE CAPABLE OF PRODUCING INTERMITTENT FULL-SIZED WAVEFORM TRACINGS, POSSIBLY PATIENT ACTIVATED; MON					
956	93268	PATIENT DEMAND SINGLE OR MULTIPLE EVENT RECORDING WITH PRESYMPTOM MEMORY LOOP, PER 30 DAY PERIOD OF TIME; INCLUDES TRANSMISSION, PHYSICIAN REVIEW AND INTERPRETATION					
956	93270	PATIENT DEMAND SINGLE OR MULTIPLE EVENT RECORDING WITH PRESYMPTOM MEMORY LOOP, PER 30 DAY PERIOD OF TIME; RECORDING (INCLUDES HOOK-UP, RECORDING, AND DISCONNECTION)					
956	93271	PATIENT DEMAND SINGLE OR MULTIPLE EVENT RECORDING WITH PRESYMPTOM MEMORY LOOP, PER 30 DAY PERIOD OF TIME; MONITORING, RECEIPT OF TRANSMISSIONS, AND ANALYSIS					
956	93278	SIGNAL-AVERAGED ELECTROCARDIOGRAPHY (SAECG), WITH OR WITHOUT ECG					
956	G0004	ECG TRANSM PHYS REVIEW & INt					
956	G0005	ECG 24 HOUR RECORDING					
956	G0006	ECG TRANSMISSION & ANALYSIS					
956	G0015	POST SYMPTOM ECG TRACING					
957	Echocardiography		S	2.83	$143.39	$117.07	$28.68
957	76825	ECHOCARDIOGRAPHY, FETAL, CARDIOVASCULAR SYSTEM, REAL TIME WITH IMAGE DOCUMENTATION (2D), WITH OR WITHOUT M-MODE RECORDING;					
957	76826	ECHOCARDIOGRAPHY, FETAL, CARDIOVASCULAR SYSTEM, REAL TIME WITH IMAGE DOCUMENTATION (2D), WITH OR WITHOUT M-MODE RECORDING; FOLLOW-UP OR REPEAT STUDY					
957	76827	DOPPLER ECHOCARDIOGRAPHY, FETAL, CARDIOVASCULAR SYSTEM, PULSED WAVE AND/OR CONTINUOUS WAVE WITH SPECTRAL DISPLAY; COMPLETE					
957	76828	DOPPLER ECHOCARDIOGRAPHY, FETAL, CARDIOVASCULAR SYSTEM, PULSED WAVE AND/OR CONTINUOUS WAVE WITH SPECTRAL DISPLAY; FOLLOW-UP OR REPEAT STUDY					
957	93303	TRANSTHORACIC ECHOCARDIOGRAPHY FOR CONGENITAL CARDIAC ANOMALIES; COMPLETE					
957	93304	TRANSTHORACIC ECHOCARDIOGRAPHY FOR CONGENITAL CARDIAC ANOMALIES; FOLLOW-UP OR LIMITED STUDY					
957	93307	ECHOCARDIOGRAPHY, TRANSTHORACIC, REAL-TIME WITH IMAGE DOCUMENTATION (2D) WITH OR WITHOUT M-MODE RECORDING; COMPLETE					
957	93308	ECHOCARDIOGRAPHY, TRANSTHORACIC, REAL-TIME WITH IMAGE DOCUMENTATION (2D) WITH OR WITHOUT M-MODE RECORDING; FOLLOW-UP OR LIMITED STUDY					
957	93312	ECHOCARDIOGRAPHY, TRANSESOPHAGEAL, REAL TIME WITH IMAGE DOCUMENTATION (2D) (WITH OR WITHOUT M-MODE RECORDING); INCLUDING PROBE PLACEMENT, IMAGE ACQUISITION, INTERPRETATION AND REPORT					
957	93313	ECHOCARDIOGRAPHY, TRANSESOPHAGEAL, REAL TIME WITH IMAGE DOCUMENTATION (2D) (WITH OR WITHOUT M-MODE RECORDING); PLACEMENT OF TRANSESOPHAGEAL PROBE ONLY					
957	93315	TRANSESOPHAGEAL ECHOCARDIOGRAPHY FOR CONGENITAL CARDIAC ANOMALIES; INCLUDING PROBE PLACEMENT, IMAGE ACQUISITION, INTERPRETATION AND REPORT					
957	93316	TRANSESOPHAGEAL ECHOCARDIOGRAPHY FOR CONGENITAL CARDIAC ANOMALIES; PLACEMENT OF TRANSESOPHAGEAL PROBE ONLY					
957	93320	DOPPLER ECHOCARDIOGRAPHY, PULSED WAVE AND/OR CONTINUOUS WAVE WITH SPECTRAL DISPLAY (LIST SEPARATELY IN ADDITION TO CODES FOR ECHOCARDIOGRAPHIC IMAGING 93303, 93304, 93307, 93308, 93312, 93314, 93315, 93317, 93350); COMPLETE					
957	93321	DOPPLER ECHOCARDIOGRAPHY, PULSED WAVE AND/OR CONTINUOUS WAVE WITH SPECTRAL DISPLAY (LIST SEPARATELY IN ADDITION TO CODES FOR ECHOCARDIOGRAPHIC IMAGING 93303, 93304, 93307, 93308, 93312, 93314, 93315, 93317, 93350); FOLLOW-UP OR LIMITED STUDY					
957	93325	DOPPLER COLOR FLOW VELOCITY MAPPING (LIST SEPARATELY IN ADDITION TO CODE FOR ECHOCARDIOGRAPHY 76825, 76826, 76827, 76828, 93303, 93304, 93307, 93308, 93312, 93314, 93315, 93317, 93320, 93321, 93350)					
957	93350	ECHOCARDIOGRAPHY, TRANSTHORACIC, REAL-TIME WITH IMAGE DOCUMENTATION (2D), WITH OR WITHOUT M-MODE RECORDING, DURING REST AND CARDIOVASCULAR STRESS TEST USING TREADMILL, BICYCLE EXERCISE AND/OR PHARMACOLOGICALLY INDUCED STRESS, WITH INTERPRETATION AND REPOR					
958	Diagnostic Cardiac Catheterization		T	26.11	$1,322.98	$659.47	$264.60
958	93501	RIGHT HEART CATHETERIZATION					
958	93503	INSERTION AND PLACEMENT OF FLOW DIRECTED CATHETER (EG, SWAN-GANZ) FOR MONITORING PURPOSES					
958	93505	ENDOMYOCARDIAL BIOPSY					
958	93510	LEFT HEART CATHETERIZATION, RETROGRADE, FROM THE BRACHIAL ARTERY, AXILLARY ARTERY OR FEMORAL ARTERY; PERCUTANEOUS					
958	93511	LEFT HEART CATHETERIZATION, RETROGRADE, FROM THE BRACHIAL ARTERY, AXILLARY ARTERY OR FEMORAL ARTERY; BY CUTDOWN					
958	93514	LEFT HEART CATHETERIZATION BY LEFT VENTRICULAR PUNCTURE					
958	93524	COMBINED TRANSSEPTAL AND RETROGRADE LEFT HEART CATHETERIZATION					
958	93526	COMBINED RIGHT HEART CATHETERIZATION AND RETROGRADE LEFT HEART CATHETERIZATION					

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
958	93527	COMBINED RIGHT HEART CATHETERIZATION AND TRANSSEPTAL LEFT HEART CATHETERIZATION THROUGH INTACT SEPTUM (WITH OR WITHOUT RETROGRADE LEFT HEART CATHETERIZATION)					
958	93528	COMBINED RIGHT HEART CATHETERIZATION WITH LEFT VENTRICULAR PUNCTURE (WITH OR WITHOUT RETROGRADE LEFT HEART CATHETERIZATION)					
958	93529	COMBINED RIGHT HEART CATHETERIZATION AND LEFT HEART CATHETERIZATION THROUGH EXISTING SEPTAL OPENING (WITH OR WITHOUT RETROGRADE LEFT HEART CATHETERIZATION)					
958	93530	RIGHT HEART CATHETERIZATION, FOR CONGENITAL CARDIAC ANOMALIES					
958	93531	COMBINED RIGHT HEART CATHETERIZATION AND RETROGRADE LEFT HEART CATHETERIZATION, FOR CONGENITAL CARDIAC ANOMALIES					
958	93532	COMBINED RIGHT HEART CATHETERIZATION AND TRANSSEPTAL LEFT HEART CATHETERIZATION THROUGH INTACT SEPTUM WITH OR WITHOUT RETROGRADE LEFT HEART CATHETERIZATION, FOR CONGENITAL CARDIAC ANOMALIES					
958	93533	COMBINED RIGHT HEART CATHETERIZATION AND TRANSSEPTAL LEFT HEART CATHETERIZATION THROUGH EXISTING SEPTAL OPENING, WITH OR WITHOUT RETROGRADE LEFT HEART CATHETERIZATION, FOR CONGENITAL CARDIAC ANOMALIES					
958	93536	PERCUTANEOUS INSERTION OF INTRA-AORTIC BALLOON CATHETER					
960	Cardiac Electrophysiologic Tests/Procedures		S	4.24	$214.84	$144.41	$42.97
960	93600	BUNDLE OF HIS RECORDING					
960	93602	INTRA-ATRIAL RECORDING					
960	93603	RIGHT VENTRICULAR RECORDING					
960	93607	LEFT VENTRICULAR RECORDING					
960	93609	INTRAVENTRICULAR AND/OR INTRA-ATRIAL MAPPING OF TACHYCARDIA SITE(S) WITH CATHETER MANIPULATION TO RECORD FROM MULTIPLE SITES TO IDENTIFY ORIGIN OF TACHYCARDIA					
960	93610	INTRA-ATRIAL PACING					
960	93612	INTRAVENTRICULAR PACING					
960	93615	ESOPHAGEAL RECORDING OF ATRIAL ELECTROGRAM WITH OR WITHOUT VENTRICULAR ELECTROGRAM(S);					
960	93616	ESOPHAGEAL RECORDING OF ATRIAL ELECTROGRAM WITH OR WITHOUT VENTRICULAR ELECTROGRAM(S); WITH PACING					
960	93618	INDUCTION OF ARRHYTHMIA BY ELECTRICAL PACING					
960	93619	COMPREHENSIVE ELECTROPHYSIOLOGIC EVALUATION WITH RIGHT ATRIAL PACING AND RECORDING, RIGHT VENTRICULAR PACING AND RECORDING, HIS BUNDLE RECORDING, INCLUDING INSERTION AND REPOSITIONING OF MULTIPLE ELECTRODE CATHETERS; WITHOUT INDUCTION OR ATTEMPTED INDUCTI					
960	93620	COMPREHENSIVE ELECTROPHYSIOLOGIC EVALUATION WITH RIGHT ATRIAL PACING AND RECORDING, RIGHT VENTRICULAR PACING AND RECORDING, HIS BUNDLE RECORDING, INCLUDING INSERTION AND REPOSITIONING OF MULTIPLE ELECTRODE CATHETERS; WITH INDUCTION OR ATTEMPTED INDUCTION					
960	93621	COMPREHENSIVE ELECTROPHYSIOLOGIC EVALUATION WITH RIGHT ATRIAL PACING AND RECORDING, RIGHT VENTRICULAR PACING AND RECORDING, HIS BUNDLE RECORDING, INCLUDING INSERTION AND REPOSITIONING OF MULTIPLE ELECTRODE CATHETERS; WITH LEFT ATRIAL RECORDINGS FROM CORON					
960	93622	COMPREHENSIVE ELECTROPHYSIOLOGIC EVALUATION WITH RIGHT ATRIAL PACING AND RECORDING, RIGHT VENTRICULAR PACING AND RECORDING, HIS BUNDLE RECORDING, INCLUDING INSERTION AND REPOSITIONING OF MULTIPLE ELECTRODE CATHETERS; WITH LEFT VENTRICULAR RECORDINGS, WITH					
960	93623	PROGRAMMED STIMULATION AND PACING AFTER INTRAVENOUS DRUG INFUSION (USE THIS CODE WITH 93620, 93621, 93622)					
960	93624	ELECTROPHYSIOLOGIC FOLLOW-UP STUDY WITH PACING AND RECORDING TO TEST EFFECTIVENESS OF THERAPY, INCLUDING INDUCTION OR ATTEMPTED INDUCTION OF ARRHYTHMIA					
960	93631	INTRA-OPERATIVE EPICARDIAL AND ENDOCARDIAL PACING AND MAPPING TO LOCALIZE THE SITE OF TACHYCARDIA OR ZONE OF SLOW CONDUCTION FOR SURGICAL CORRECTION					
960	93640	ELECTROPHYSIOLOGIC EVALUATION OF CARDIOVERTER-DEFIBRILLATOR LEADS (INCLUDES DEFIBRILLATION THRESHOLD TESTING AND SENSING FUNCTION) AT TIME OF INITIAL IMPLANTATION OR REPLACEMENT;					
960	93641	ELECTROPHYSIOLOGIC EVALUATION OF CARDIOVERTER-DEFIBRILLATOR LEADS (INCLUDES DEFIBRILLATION THRESHOLD TESTING AND SENSING FUNCTION) AT TIME OF INITIAL IMPLANTATION OR REPLACEMENT; WITH TESTING OF CARDIOVERTER-DEFIBRILLATOR PULSE GENERATOR					
960	93642	ELECTROPHYSIOLOGIC EVALUATION OF CARDIOVERTER-DEFIBRILLATOR (INCLUDES DEFIBRILLATION THRESHOLD EVALUATION, INDUCTION OF ARRHYTHMIA, EVALUATION OF SENSING AND PACING FOR ARRHYTHMIA TERMINATION, AND PROGRAMMING OR REPROGRAMMING OF SENSING OR THERAPEUTIC PAR					
960	93650	INTRACARDIAC CATHETER ABLATION OF ATRIOVENTRICULAR NODE FUNCTION, ATRIOVENTRICULAR CONDUCTION FOR CREATION OF COMPLETE HEART BLOCK, WITH OR WITHOUT TEMPORARY PACEMAKER PLACEMENT					
960	93651	INTRACARDIAC CATHETER ABLATION OF ARRHYTHMOGENIC FOCUS; FOR TREATMENT OF SUPRAVENTRICULAR TACHYCARDIA BY ABLATION OF FAST OR SLOW ATRIOVENTRICULAR PATHWAYS, ACCESSORY ATRIOVENTRICULAR CONNECTIONS OR OTHER ATRIAL FOCI, SINGLY OR IN COMBINATION					
960	93652	INTRACARDIAC CATHETER ABLATION OF ARRHYTHMOGENIC FOCUS; FOR TREATMENT OF VENTRICULAR TACHYCARDIA					
960	93660	EVALUATION OF CARDIOVASCULAR FUNCTION WITH TILT TABLE EVALUATION, WITH CONTINUOUS ECG MONITORING AND INTERMITTENT BLOOD PRESSURE MONITORING, WITH OR WITHOUT PHARMACOLOGICAL INTERVENTION					
960	93724	ELECTRONIC ANALYSIS OF ANTITACHYCARDIA PACEMAKER SYSTEM (INCLUDES ELECTROCARDIOGRAPHIC RECORDING, PROGRAMMING OF DEVICE, INDUCTION AND TERMINATION OF TACHYCARDIA VIA IMPLANTED PACEMAKER, AND INTERPRETATION OF RECORDINGS)					
966	Electronic Analysis of Pacemakers/other devices		X	0.39	$19.76	$12.43	$3.95
966	62367	ELECTRONIC ANALYSIS OF PROGRAMMABLE, IMPLANTED PUMP FOR INTRATHECAL OR EPIDURAL DRUG INFUSION (INCLUDES EVALUATION OF RESERVOIR STATUS, ALARM STATUS, DRUG PRESCRIPTION STATUS); WITHOUT REPROGRAMMING					
966	62368	ELECTRONIC ANALYSIS OF PROGRAMMABLE, IMPLANTED PUMP FOR INTRATHECAL OR EPIDURAL DRUG INFUSION (INCLUDES EVALUATION OF RESERVOIR STATUS, ALARM STATUS, DRUG PRESCRIPTION STATUS); WITH REPROGRAMMING					
966	63690	ELECTRONIC ANALYSIS OF IMPLANTED NEUROSTIMULATOR PULSE GENERATOR SYSTEM (MAY INCLUDE RATE, PULSE AMPLITUDE AND DURATION, CONFIGURATION OF WAVE FORM, BATTERY STATUS, ELECTRODE SELECTABILITY, OUTPUT MODULATION, CYCLING, IMPEDANCE AND PATIENT COMPLIANCE MEAS					
966	63691	ELECTRONIC ANALYSIS OF IMPLANTED NEUROSTIMULATOR PULSE GENERATOR SYSTEM (MAY INCLUDE RATE, PULSE AMPLITUDE AND DURATION, CONFIGURATION OF WAVE FORM, BATTERY STATUS, ELECTRODE SELECTABILITY, OUTPUT MODULATION, CYCLING, IMPEDANCE AND PATIENT COMPLIANCE MEAS					

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
966	93731	ELECTRONIC ANALYSIS OF DUAL-CHAMBER PACEMAKER SYSTEM (INCLUDES EVALUATION OF PROGRAMMABLE PARAMETERS AT REST AND DURING ACTIVITY WHERE APPLICABLE, USING ELECTROCARDIOGRAPHIC RECORDING AND INTERPRETATION OF RECORDINGS AT REST AND DURING EXERCISE, ANALYSIS					
966	93732	ELECTRONIC ANALYSIS OF DUAL-CHAMBER PACEMAKER SYSTEM (INCLUDES EVALUATION OF PROGRAMMABLE PARAMETERS AT REST AND DURING ACTIVITY WHERE APPLICABLE, USING ELECTROCARDIOGRAPHIC RECORDING AND INTERPRETATION OF RECORDINGS AT REST AND DURING EXERCISE, ANALYSIS					
966	93733	ELECTRONIC ANALYSIS OF DUAL CHAMBER INTERNAL PACEMAKER SYSTEM (MAY INCLUDE RATE, PULSE AMPLITUDE AND DURATION, CONFIGURATION OF WAVE FORM, AND/OR TESTING OF SENSORY FUNCTION OF PACEMAKER), TELEPHONIC ANALYSIS					
966	93734	ELECTRONIC ANALYSIS OF SINGLE CHAMBER PACEMAKER SYSTEM (INCLUDES EVALUATION OF PROGRAMMABLE PARAMETERS AT REST AND DURING ACTIVITY WHERE APPLICABLE, USING ELECTROCARDIOGRAPHIC RECORDING AND INTERPRETATION OF RECORDINGS AT REST AND DURING EXERCISE, ANALYSI					
966	93735	ELECTRONIC ANALYSIS OF SINGLE CHAMBER PACEMAKER SYSTEM (INCLUDES EVALUATION OF PROGRAMMABLE PARAMETERS AT REST AND DURING ACTIVITY WHERE APPLICABLE, USING ELECTROCARDIOGRAPHIC RECORDING AND INTERPRETATION OF RECORDINGS AT REST AND DURING EXERCISE, ANALYSI					
966	93736	ELECTRONIC ANALYSIS OF SINGLE CHAMBER INTERNAL PACEMAKER SYSTEM (MAY INCLUDE RATE, PULSE AMPLITUDE AND DURATION, CONFIGURATION OF WAVE FORM, AND/OR TESTING OF SENSORY FUNCTION OF PACEMAKER), TELEPHONIC ANALYSIS					
966	93737	ELECTRONIC ANALYSIS OF CARDIOVERTER/DEFIBRILLATOR ONLY (INTERROGATION, EVALUATION OF PULSE GENERATOR STATUS); WITHOUT REPROGRAMMING					
966	93738	ELECTRONIC ANALYSIS OF CARDIOVERTER/DEFIBRILLATOR ONLY (INTERROGATION, EVALUATION OF PULSE GENERATOR STATUS); WITH REPROGRAMMING					
967	Non-Invasive Vascular Studies		X	1.70	$86.14	$57.40	$17.23
967	93720	PLETHYSMOGRAPHY, TOTAL BODY; WITH INTERPRETATION AND REPORT					
967	93721	PLETHYSMOGRAPHY, TOTAL BODY; TRACING ONLY, WITHOUT INTERPRETATION AND REPORT					
967	93740	TEMPERATURE GRADIENT STUDIES					
967	93799	UNLISTED CARDIOVASCULAR SERVICE OR PROCEDURE					
967	93922	NON-INVASIVE PHYSIOLOGIC STUDIES OF UPPER OR LOWER EXTREMITY ARTERIES, SINGLE LEVEL, BILATERAL (EG, ANKLE/BRACHIAL INDICES, DOPPLER WAVEFORM ANALYSIS, VOLUME PLETHYSMOGRAPHY, TRANSCUTANEOUS OXYGEN TENSION MEASUREMENT)					
967	93923	NON-INVASIVE PHYSIOLOGIC STUDIES OF UPPER OR LOWER EXTREMITY ARTERIES, MULTIPLE LEVELS OR WITH PROVOCATIVE FUNCTIONAL MANEUVERS, COMPLETE BILATERAL STUDY (EG, SEGMENTAL BLOOD PRESSURE MEASUREMENTS, SEGMENTAL DOPPLER WAVEFORM ANALYSIS, SEGMENTAL VOLUME PLE					
967	93924	NON-INVASIVE PHYSIOLOGIC STUDIES OF LOWER EXTREMITY ARTERIES, AT REST AND FOLLOWING TREADMILL STRESS TESTING, COMPLETE BILATERAL STUDY					
967	93965	NON-INVASIVE PHYSIOLOGIC STUDIES OF EXTREMITY VEINS, COMPLETE BILATERAL STUDY (EG, DOPPLER WAVEFORM ANALYSIS WITH RESPONSES TO COMPRESSION AND OTHER MANEUVERS, PHLEBORHEOGRAPHY, IMPEDANCE PLETHYSMOGRAPHY)					
968	Vascular Ultrasound		X	2.37	$120.09	$79.55	$24.02
968	93875	NON-INVASIVE PHYSIOLOGIC STUDIES OF EXTRACRANIAL ARTERIES, COMPLETE BILATERAL STUDY (EG, PERIORBITAL FLOW DIRECTION WITH ARTERIAL COMPRESSION, OCULAR PNEUMOPLETHYSMOGRAPHY, DOPPLER ULTRASOUND SPECTRAL ANALYSIS)					
968	93880	DUPLEX SCAN OF EXTRACRANIAL ARTERIES; COMPLETE BILATERAL STUDY					
968	93882	DUPLEX SCAN OF EXTRACRANIAL ARTERIES; UNILATERAL OR LIMITED STUDY					
968	93886	TRANSCRANIAL DOPPLER STUDY OF THE INTRACRANIAL ARTERIES; COMPLETE STUDY					
968	93888	TRANSCRANIAL DOPPLER STUDY OF THE INTRACRANIAL ARTERIES; LIMITED STUDY					
968	93925	DUPLEX SCAN OF LOWER EXTREMITY ARTERIES OR ARTERIAL BYPASS GRAFTS; COMPLETE BILATERAL STUDY					
968	93926	DUPLEX SCAN OF LOWER EXTREMITY ARTERIES OR ARTERIAL BYPASS GRAFTS; UNILATERAL OR LIMITED STUDY					
968	93930	DUPLEX SCAN OF UPPER EXTREMITY ARTERIES OR ARTERIAL BYPASS GRAFTS; COMPLETE BILATERAL STUDY					
968	93931	DUPLEX SCAN OF UPPER EXTREMITY ARTERIES OR ARTERIAL BYPASS GRAFTS; UNILATERAL OR LIMITED STUDY					
968	93970	DUPLEX SCAN OF EXTREMITY VEINS INCLUDING RESPONSES TO COMPRESSION AND OTHER MANEUVERS; COMPLETE BILATERAL STUDY					
968	93971	DUPLEX SCAN OF EXTREMITY VEINS INCLUDING RESPONSES TO COMPRESSION AND OTHER MANEUVERS; UNILATERAL OR LIMITED STUDY					
968	93975	DUPLEX SCAN OF ARTERIAL INFLOW AND VENOUS OUTFLOW OF ABDOMINAL, PELVIC, SCROTAL CONTENTS AND/OR RETROPERITONEAL ORGANS; COMPLETE STUDY					
968	93976	DUPLEX SCAN OF ARTERIAL INFLOW AND VENOUS OUTFLOW OF ABDOMINAL, PELVIC, SCROTAL CONTENTS AND/OR RETROPERITONEAL ORGANS; LIMITED STUDY					
968	93978	DUPLEX SCAN OF AORTA, INFERIOR VENA CAVA, ILIAC VASCULATURE, OR BYPASS GRAFTS; COMPLETE STUDY					
968	93979	DUPLEX SCAN OF AORTA, INFERIOR VENA CAVA, ILIAC VASCULATURE, OR BYPASS GRAFTS; UNILATERAL OR LIMITED STUDY					
968	93980	DUPLEX SCAN OF ARTERIAL INFLOW AND VENOUS OUTFLOW OF PENILE VESSELS; COMPLETE STUDY					
968	93981	DUPLEX SCAN OF ARTERIAL INFLOW AND VENOUS OUTFLOW OF PENILE VESSELS; FOLLOW-UP OR LIMITED STUDY					
968	93990	DUPLEX SCAN OF HEMODIALYSIS ACCESS (INCLUDING ARTERIAL INFLOW, BODY OF ACCESS AND VENOUS OUTFLOW)					
969	Hyperbaric Oxygen		S	2.65	$134.27	$141.70	$26.85
969	99183	PHYSICIAN ATTENDANCE AND SUPERVISION OF HYPERBARIC OXYGEN THERAPY, PER SESSION					
971	Level I Pulmonary Tests		X	0.78	$39.52	$21.47	$7.90
971	94010	SPIROMETRY, INCLUDING GRAPHIC RECORD, TOTAL AND TIMED VITAL CAPACITY, EXPIRATORY FLOW RATE MEASUREMENT(S), WITH OR WITHOUT MAXIMAL VOLUNTARY VENTILATION					
971	94060	BRONCHOSPASM EVALUATION: SPIROMETRY AS IN 94010, BEFORE AND AFTER BRONCHODILATOR (AEROSOL OR PARENTERAL) OR EXERCISE					
971	94200	MAXIMUM BREATHING CAPACITY, MAXIMAL VOLUNTARY VENTILATION					
971	94250	EXPIRED GAS COLLECTION, QUANTITATIVE, SINGLE PROCEDURE (SEPARATE PROCEDURE)					
971	94260	THORACIC GAS VOLUME					
971	94360	DETERMINATION OF RESISTANCE TO AIRFLOW, OSCILLATORY OR PLETHYSMOGRAPHIC METHODS					
971	94375	RESPIRATORY FLOW VOLUME LOOP					
971	94400	BREATHING RESPONSE TO CO2 (CO2 RESPONSE CURVE)					
971	94450	BREATHING RESPONSE TO HYPOXIA (HYPOXIA RESPONSE CURVE)					

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
971	94762	NONINVASIVE EAR OR PULSE OXIMETRY FOR OXYGEN SATURATION; BY CONTINUOUS OVERNIGHT MONITORING (SEPARATE PROCEDURE)					
971	94770	CARBON DIOXIDE, EXPIRED GAS DETERMINATION BY INFRARED ANALYZER					
971	94799	UNLISTED PULMONARY SERVICE OR PROCEDURE					
972	Level II Pulmonary Tests		X	1.02	$51.68	$29.38	$10.34
972	94240	FUNCTIONAL RESIDUAL CAPACITY OR RESIDUAL VOLUME: HELIUM METHOD, NITROGEN OPEN CIRCUIT METHOD, OR OTHER METHOD					
972	94350	DETERMINATION OF MALDISTRIBUTION OF INSPIRED GAS: MULTIPLE BREATH NITROGEN WASHOUT CURVE INCLUDING ALVEOLAR NITROGEN OR HELIUM EQUILIBRATION TIME					
972	94370	DETERMINATION OF AIRWAY CLOSING VOLUME, SINGLE BREATH TESTS					
972	94680	OXYGEN UPTAKE, EXPIRED GAS ANALYSIS; REST AND EXERCISE, DIRECT, SIMPLE					
972	94681	OXYGEN UPTAKE, EXPIRED GAS ANALYSIS; INCLUDING CO2 OUTPUT, PERCENTAGE OXYGEN EXTRACTED					
972	94690	OXYGEN UPTAKE, EXPIRED GAS ANALYSIS; REST, INDIRECT (SEPARATE PROCEDURE)					
972	94720	CARBON MONOXIDE DIFFUSING CAPACITY, ANY METHOD					
972	94725	MEMBRANE DIFFUSION CAPACITY					
973	Level III Pulmonary Tests		S	1.89	$95.77	$55.82	$19.15
973	94070	PROLONGED POSTEXPOSURE EVALUATION OF BRONCHOSPASM WITH MULTIPLE SPIROMETRIC DETERMINATIONS AFTER ANTIGEN, COLD AIR, METHACHOLINE OR OTHER CHEMICAL AGENT, WITH SPIROMETRY AS IN 94010					
973	94620	PULMONARY STRESS TESTING, SIMPLE OR COMPLEX					
973	94750	PULMONARY COMPLIANCE STUDY, ANY METHOD					
973	94772	CIRCADIAN RESPIRATORY PATTERN RECORDING (PEDIATRIC PNEUMOGRAM), 12 TO 24 HOUR CONTINUOUS RECORDING, INFANT					
973	95070	INHALATION BRONCHIAL CHALLENGE TESTING (NOT INCLUDING NECESSARY PULMONARY FUNCTION TESTS); WITH HISTAMINE, METHACHOLINE, OR SIMILAR COMPOUNDS					
973	95071	INHALATION BRONCHIAL CHALLENGE TESTING (NOT INCLUDING NECESSARY PULMONARY FUNCTION TESTS); WITH ANTIGENS OR GASES, SPECIFY					
976	Pulmonary Therapy		S	0.44	$22.29	$14.92	$4.46
976	94640	NONPRESSURIZED INHALATION TREATMENT FOR ACUTE AIRWAY OBSTRUCTION					
976	94642	AEROSOL INHALATION OF PENTAMIDINE FOR PNEUMOCYSTIS CARINII PNEUMONIA TREATMENT OR PROPHYLAXIS					
976	94650	INTERMITTENT POSITIVE PRESSURE BREATHING (IPPB) TREATMENT, AIR OR OXYGEN, WITH OR WITHOUT NEBULIZED MEDICATION; INITIAL DEMONSTRATION AND/OR EVALUATION					
976	94651	INTERMITTENT POSITIVE PRESSURE BREATHING (IPPB) TREATMENT, AIR OR OXYGEN, WITH OR WITHOUT NEBULIZED MEDICATION; SUBSEQUENT					
976	94657	VENTILATION ASSIST AND MANAGEMENT, INITIATION OF PRESSURE OR VOLUME PRESET VENTILATORS FOR ASSISTED OR CONTROLLED BREATHING; SUBSEQUENT DAYS					
976	94660	CONTINUOUS POSITIVE AIRWAY PRESSURE VENTILATION (CPAP), INITIATION AND MANAGEMENT					
976	94662	CONTINUOUS NEGATIVE PRESSURE VENTILATION (CNP), INITIATION AND MANAGEMENT					
976	94664	AEROSOL OR VAPOR INHALATIONS FOR SPUTUM MOBILIZATION, BRONCHODILATION, OR SPUTUM INDUCTION FOR DIAGNOSTIC PURPOSES; INITIAL DEMONSTRATION AND/OR EVALUATION					
976	94665	AEROSOL OR VAPOR INHALATIONS FOR SPUTUM MOBILIZATION, BRONCHODILATION, OR SPUTUM INDUCTION FOR DIAGNOSTIC PURPOSES; SUBSEQUENT					
977	Allergy Tests		X	0.63	$31.92	$12.66	$6.38
977	95004	PERCUTANEOUS TESTS (SCRATCH, PUNCTURE, PRICK) WITH ALLERGENIC EXTRACTS, IMMEDIATE TYPE REACTION, SPECIFY NUMBER OF TESTS					
977	95010	PERCUTANEOUS TESTS (SCRATCH, PUNCTURE, PRICK) SEQUENTIAL AND INCREMENTAL, WITH DRUGS, BIOLOGICALS OR VENOMS, IMMEDIATE TYPE REACTION, SPECIFY NUMBER OF TESTS					
977	95015	INTRACUTANEOUS (INTRADERMAL) TESTS, SEQUENTIAL AND INCREMENTAL, WITH DRUGS, BIOLOGICALS, OR VENOMS, IMMEDIATE TYPE REACTION, SPECIFY NUMBER OF TESTS					
977	95024	INTRACUTANEOUS (INTRADERMAL) TESTS WITH ALLERGENIC EXTRACTS, IMMEDIATE TYPE REACTION, SPECIFY NUMBER OF TESTS					
977	95027	SKIN END POINT TITRATION					
977	95028	INTRACUTANEOUS (INTRADERMAL) TESTS WITH ALLERGENIC EXTRACTS, DELAYED TYPE REACTION, INCLUDING READING, SPECIFY NUMBER OF TESTS					
977	95044	PATCH OR APPLICATION TEST(S) (SPECIFY NUMBER OF TESTS)					
977	95052	PHOTO PATCH TEST(S) (SPECIFY NUMBER OF TESTS)					
977	95056	PHOTO TESTS					
977	95060	OPHTHALMIC MUCOUS MEMBRANE TESTS					
977	95065	DIRECT NASAL MUCOUS MEMBRANE TEST					
977	95078	PROVOCATIVE TESTING (EG, RINKEL TEST)					
977	95180	RAPID DESENSITIZATION PROCEDURE, EACH HOUR (EG, INSULIN, PENICILLIN, HORSE SERUM)					
977	95199	UNLISTED ALLERGY/CLINICAL IMMUNOLOGIC SERVICE OR PROCEDURE					
978	Allergy Injections		X	0.31	$15.71	$3.39	$3.14
978	95115	PROFESSIONAL SERVICES FOR ALLERGEN IMMUNOTHERAPY NOT INCLUDING PROVISION OF ALLERGENIC EXTRACTS; SINGLE INJECTION					
978	95117	PROFESSIONAL SERVICES FOR ALLERGEN IMMUNOTHERAPY NOT INCLUDING PROVISION OF ALLERGENIC EXTRACTS; TWO OR MORE INJECTIONS					
978	95144	PROFESSIONAL SERVICES FOR THE SUPERVISION AND PROVISION OF ANTIGENS FOR ALLERGEN IMMUNOTHERAPY, SINGLE OR MULTIPLE ANTIGENS, SINGLE DOSE VIALS (SPECIFY NUMBER OF VIALS)					
978	95145	PROFESSIONAL SERVICES FOR THE SUPERVISION AND PROVISION OF ANTIGENS FOR ALLERGEN IMMUNOTHERAPY (SPECIFY NUMBER OF DOSES); SINGLE STINGING INSECT VENOM					
978	95146	PROFESSIONAL SERVICES FOR THE SUPERVISION AND PROVISION OF ANTIGENS FOR ALLERGEN IMMUNOTHERAPY (SPECIFY NUMBER OF DOSES); TWO SINGLE STINGING INSECT VENOMS					
978	95147	PROFESSIONAL SERVICES FOR THE SUPERVISION AND PROVISION OF ANTIGENS FOR ALLERGEN IMMUNOTHERAPY (SPECIFY NUMBER OF DOSES); THREE SINGLE STINGING INSECT VENOMS					

(See Addendum D. for Payment of Medical Visits)

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
978	95148	PROFESSIONAL SERVICES FOR THE SUPERVISION AND PROVISION OF ANTIGENS FOR ALLERGEN IMMUNOTHERAPY (SPECIFY NUMBER OF DOSES); FOUR SINGLE STINGING INSECT VENOMS					
978	95165	PROFESSIONAL SERVICES FOR THE SUPERVISION AND PROVISION OF ANTIGENS FOR ALLERGEN IMMUNOTHERAPY; SINGLE OR MULTIPLE ANTIGENS (SPECIFY NUMBER OF DOSES)					
979	Extended EEG Studies and Sleep Studies		S	10.17	$515.31	$288.83	$103.06
979	95805	MULTIPLE SLEEP LATENCY OR MAINTENANCE OF WAKEFULNESS TESTING, RECORDING, ANALYSIS AND INTERPRETATION OF PHYSIOLOGICAL MEASUREMENTS OF SLEEP DURING MULTIPLE TRIALS TO ASSESS SLEEPINESS					
979	95806	SLEEP STUDY, SIMULTANEOUS RECORDING OF VENTILATION, RESPIRATORY EFFORT, ECG OR HEART RATE, AND OXYGEN SATURATION, UNATTENDED BY A TECHNOLOGIST					
979	95807	SLEEP STUDY, SIMULTANEOUS RECORDING OF VENTILATION, RESPIRATORY EFFORT, ECG OR HEART RATE, AND OXYGEN SATURATION, ATTENDED BY A TECHNOLOGIST					
979	95808	POLYSOMNOGRAPHY; SLEEP STAGING WITH 1-3 ADDITIONAL PARAMETERS OF SLEEP, ATTENDED BY A TECHNOLOGIST					
979	95810	POLYSOMNOGRAPHY; OF SLEEP, ATTENDED BY A TECHNOLOGIST SLEEP STAGING WITH 4 OR MORE ADDITIONAL PARAMETERS OF SLEEP, ATTENDED BY A TECHNOLOGIST					
979	95811	POLYSOMNOGRAPHY; OF SLEEP, ATTENDED BY A TECHNOLOGIST SLEEP STAGING WITH 4 OR MORE ADDITIONAL PARAMETERS OF SLEEP, WITH INITIATION OF CONTINUOUS POSITIVE AIRWAY PRESSURE THERAPY OR BILEVEL VENTILATION, ATTENDED BY A TECHNOLOGIST					
979	95812	ELECTROENCEPHALOGRAM (EEG) EXTENDED MONITORING; UP TO ONE HOUR					
979	95813	ELECTROENCEPHALOGRAM (EEG) EXTENDED MONITORING; GREATER THAN ONE HOUR					
979	95827	ELECTROENCEPHALOGRAM (EEG); ALL NIGHT SLEEP ONLY					
979	95951	MONITORING FOR LOCALIZATION OF CEREBRAL SEIZURE FOCUS BY CABLE OR RADIO, 16 OR MORE CHANNEL TELEMETRY, COMBINED ELECTROENCEPHALOGRAPHIC (EEG) AND VIDEO RECORDING AND INTERPRETATION (EG, FOR PRESURGICAL LOCALIZATION), EACH 24 HOURS					
979	95953	MONITORING FOR LOCALIZATION OF CEREBRAL SEIZURE FOCUS BY COMPUTERIZED PORTABLE 16 OR MORE CHANNEL EEG, ELECTROENCEPHALOGRAPHIC (EEG) RECORDING AND INTERPRETATION, EACH 24 HOURS					
979	95954	PHARMACOLOGICAL OR PHYSICAL ACTIVATION REQUIRING PHYSICIAN ATTENDANCE DURING EEG RECORDING OF ACTIVATION PHASE (EG, THIOPENTAL ACTIVATION TEST)					
979	95956	MONITORING FOR LOCALIZATION OF CEREBRAL SEIZURE FOCUS BY CABLE OR RADIO, 16 OR MORE CHANNEL TELEMETRY, ELECTROENCEPHALOGRAPHIC (EEG) RECORDING AND INTERPRETATION, EACH 24 HOURS					
979	95958	WADA ACTIVATION TEST FOR HEMISPHERIC FUNCTION, INCLUDING ELECTROENCEPHALOGRAPHIC (EEG) MONITORING					
980	Electroencephalogram		S	2.15	$108.94	$57.86	$21.79
980	92275	ELECTRORETINOGRAPHY WITH INTERPRETATION AND REPORT					
980	95857	TENSILON TEST FOR MYASTHENIA GRAVIS;					
980	95867	NEEDLE ELECTROMYOGRAPHY, CRANIAL NERVE SUPPLIED MUSCLES, UNILATERAL					
980	95869	NEEDLE ELECTROMYOGRAPHY; THORACIC PARASPINAL MUSCLES					
980	95870	NEEDLE ELECTROMYOGRAPHY; OTHER THAN PARASPINAL (EG, ABDOMEN, THORAX)					
980	95900	NERVE CONDUCTION, AMPLITUDE AND LATENCY/VELOCITY STUDY, EACH NERVE, ANY/ALL SITE(S) ALONG THE NERVE; MOTOR, WITHOUT F-WAVE STUDY					
980	95921	TESTING OF AUTONOMIC NERVOUS SYSTEM FUNCTION; CARDIOVAGAL INNERVATION (PARASYMPATHETIC FUNCTION), INCLUDING TWO OR MORE OF THE FOLLOWING: HEART RATE RESPONSE TO DEEP BREATHING WITH RECORDED R-R INTERVAL, VALSALVA RATIO, AND 30:15 RATIO					
980	95922	TESTING OF AUTONOMIC NERVOUS SYSTEM FUNCTION; VASOMOTOR ADRENERGIC INNERVATION (SYMPATHETIC ADRENERGIC FUNCTION), INCLUDING BEAT-TO-BEAT BLOOD PRESSURE AND R-R INTERVAL CHANGES DURING VALSALVA MANEUVER AND AT LEAST FIVE MINUTES OF PASSIVE TILT					
980	95923	TESTING OF AUTONOMIC NERVOUS SYSTEM FUNCTION; SUDOMOTOR, INCLUDING ONE OR MORE OF THE FOLLOWING: QUANTITATIVE SUDOMOTOR AXON REFLEX TEST (QSART), SILASTIC SWEAT IMPRINT, THERMOREGULATORY SWEAT TEST, AND CHANGES IN SYMPATHETIC SKIN POTENTIAL					
980	95926	SHORT-LATENCY SOMATOSENSORY EVOKED POTENTIAL STUDY, STIMULATION OF ANY/ALL PERIPHERAL NERVES OR SKIN SITES, RECORDING FROM THE CENTRAL NERVOUS SYSTEM; IN LOWER LIMBS					
980	95927	SHORT-LATENCY SOMATOSENSORY EVOKED POTENTIAL STUDY, STIMULATION OF ANY/ALL PERIPHERAL NERVES OR SKIN SITES, RECORDING FROM THE CENTRAL NERVOUS SYSTEM; IN THE TRUNK OR HEAD					
980	95930	VISUAL EVOKED POTENTIAL (VEP) TESTING CENTRAL NERVOUS SYSTEM, CHECKERBOARD OR FLASH					
980	95933	ORBICULARIS OCULI (BLINK) REFLEX, BY ELECTRODIAGNOSTIC TESTING					
980	95934	H-REFLEX, AMPLITUDE AND LATENCY STUDY; RECORD GASTROCNEMIUS/SOLEUS MUSCLE					
980	95936	H-REFLEX, AMPLITUDE AND LATENCY STUDY; RECORD MUSCLE OTHER THAN GASTROCNEMIUS/SOLEUS MUSCLE					
980	95937	NEUROMUSCULAR JUNCTION TESTING (REPETITIVE STIMULATION, PAIRED STIMULI), EACH NERVE, ANY ONE METHOD					
980	95950	MONITORING FOR IDENTIFICATION AND LATERALIZATION OF CEREBRAL SEIZURE FOCUS, ELECTROENCEPHALOGRAPHIC (EG, 8 CHANNEL EEG) RECORDING AND INTERPRETATION, EACH 24 HOURS					
981	Level I Nerve and Muscle Tests		X	1.46	$73.98	$41.81	$14.80
981	92585	AUDITORY EVOKED POTENTIALS FOR EVOKED RESPONSE AUDIOMETRY AND/OR TESTING OF THE CENTRAL NERVOUS SYSTEM					
981	95858	TENSILON TEST FOR MYASTHENIA GRAVIS; WITH ELECTROMYOGRAPHIC RECORDING					
981	95860	NEEDLE ELECTROMYOGRAPHY, ONE EXTREMITY WITH OR WITHOUT RELATED PARASPINAL AREAS					
981	95861	NEEDLE ELECTROMYOGRAPHY, TWO EXTREMITIES WITH OR WITHOUT RELATED PARASPINAL AREAS					
981	95863	NEEDLE ELECTROMYOGRAPHY, THREE EXTREMITIES WITH OR WITHOUT RELATED PARASPINAL AREAS					
981	95864	NEEDLE ELECTROMYOGRAPHY, FOUR EXTREMITIES WITH OR WITHOUT RELATED PARASPINAL AREAS					
981	95868	NEEDLE ELECTROMYOGRAPHY, CRANIAL NERVE SUPPLIED MUSCLES, BILATERAL					
981	95872	NEEDLE ELECTROMYOGRAPHY USING SINGLE FIBER ELECTRODE, WITH QUANTITATIVE MEASUREMENT OF JITTER, BLOCKING AND/OR FIBER DENSITY, ANY/ALL SITES OF EACH MUSCLE STUDIED					
981	95875	ISCHEMIC LIMB EXERCISE WITH NEEDLE ELECTROMYOGRAPHY, WITH LACTIC ACID DETERMINATION					
981	95903	NERVE CONDUCTION, AMPLITUDE AND LATENCY/VELOCITY STUDY, EACH NERVE, ANY/ALL SITE(S) ALONG THE NERVE; MOTOR, WITH F-WAVE STUDY					
981	95904	NERVE CONDUCTION, AMPLITUDE AND LATENCY/VELOCITY STUDY, EACH NERVE, ANY/ALL SITE(S) ALONG THE NERVE; SENSORY					
981	95920	INTRAOPERATIVE NEUROPHYSIOLOGY TESTING, PER HOUR					

(See Addendum D. for Payment of Medical Visits)

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT [1]/ HCPCS [2]	HCPCS Description	Status indicator	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
981	95925	SHORT-LATENCY SOMATOSENSORY EVOKED POTENTIAL STUDY, STIMULATION OF ANY/ALL PERIPHERAL NERVES OR SKIN SITES, RECORDING FROM THE CENTRAL NERVOUS SYSTEM; IN UPPER LIMBS					
982	Level II Nerve and Muscle Tests		X	1.39	$70.43	$38.87	$14.09
982	92585	Auditory evoked potential					
982	95858	Tensilon test & myogram					
982	95860	Muscle test, one limb					
982	95861	Muscle test, two limbs					
982	95863	Muscle test, 3 limbs					
982	95864	Muscle test, 4 limbs					
982	95868	Muscle test, head or neck					
982	95872	Muscle test, one fiber					
982	95875	Limb exercise test					
982	95925	Somatosensory testing					
987	Subcutaneous or Intramuscular Chemotherapy		S	.65	$32.94	$13.33	$6.59
987	96400	CHEMOTHERAPY ADMINISTRATION, SUBCUTANEOUS OR INTRAMUSCULAR, WITH OR WITHOUT LOCAL ANESTHESIA					
987	96405	CHEMOTHERAPY ADMINISTRATION, INTRALESIONAL; UP TO AND INCLUDING 7 LESIONS					
987	96406	CHEMOTHERAPY ADMINISTRATION, INTRALESIONAL; MORE THAN 7 LESIONS					
987	96549	UNLISTED CHEMOTHERAPY PROCEDURE					
987	Q0083	Chemo other than infusion					
988	Chemotherapy except by Extended Infusion		S	4.15	$210.28	$97.52	$42.06
988	96408	CHEMOTHERAPY ADMINISTRATION, INTRAVENOUS; PUSH TECHNIQUE					
988	96410	CHEMOTHERAPY ADMINISTRATION, INTRAVENOUS; INFUSION TECHNIQUE, UP TO ONE HOUR					
988	96412	CHEMOTHERAPY ADMINISTRATION, INTRAVENOUS; INFUSION TECHNIQUE, ONE TO 8 HOURS, EACH ADDITIONAL HOUR					
988	96420	CHEMOTHERAPY ADMINISTRATION, INTRA-ARTERIAL; PUSH TECHNIQUE					
988	96422	CHEMOTHERAPY ADMINISTRATION, INTRA-ARTERIAL; INFUSION TECHNIQUE, UP TO ONE HOUR					
988	96423	CHEMOTHERAPY ADMINISTRATION, INTRA-ARTERIAL; INFUSION TECHNIQUE, ONE TO 8 HOURS, EACH ADDITIONAL HOUR					
989	Chemotherapy by Extended Infusion		S	1.72	$87.15	$40.68	$17.43
989	96414	CHEMOTHERAPY ADMINISTRATION, INTRAVENOUS; INFUSION TECHNIQUE, INITIATION OF PROLONGED INFUSION (MORE THAN 8 HOURS), REQUIRING THE USE OF A PORTABLE OR IMPLANTABLE PUMP					
989	96425	CHEMOTHERAPY ADMINISTRATION, INTRA-ARTERIAL; INFUSION TECHNIQUE, INITIATION OF PROLONGED INFUSION (MORE THAN 8 HOURS), REQUIRING THE USE OF A PORTABLE OR IMPLANTABLE PUMP					
989	96440	CHEMOTHERAPY ADMINISTRATION INTO PLEURAL CAVITY, REQUIRING AND INCLUDING THORACENTESIS					
989	96445	CHEMOTHERAPY ADMINISTRATION INTO PERITONEAL CAVITY, REQUIRING AND INCLUDING PERITONEOCENTESIS					
989	96450	CHEMOTHERAPY ADMINISTRATION, INTO CNS (EG, INTRATHECAL), REQUIRING AND INCLUDING LUMBAR PUNCTURE					
989	96542	CHEMOTHERAPY INJECTION, SUBARACHNOID OR INTRAVENTRICULAR VIA SUBCUTANEOUS RESERVOIR, SINGLE OR MULTIPLE AGENTS					
989	Q0084	Chemo, infusion only					
989	Q0085	Chemo, infusion and other technique					
990	Photochemotherapy		S	.43	$21.79	$8.14	$4.36
990	96900	ACTINOTHERAPY (ULTRAVIOLET LIGHT)					
990	96910	PHOTOCHEMOTHERAPY; TAR AND ULTRAVIOLET B (GOECKERMAN TREATMENT) OR PETROLATUM AND ULTRAVIOLET B					
990	96912	PHOTOCHEMOTHERAPY; PSORALENS AND ULTRAVIOLET A (PUVA)					
990	96913	PHOTOCHEMOTHERAPY (GOECKERMAN AND/OR PUVA) FOR SEVERE PHOTORESPONSIVE DERMATOSES REQUIRING AT LEAST FOUR TO EIGHT HOURS OF CARE UNDER DIRECT SUPERVISION OF THE PHYSICIAN (INCLUDES APPLICATION OF MEDICATION AND DRESSINGS)					
990	96999	UNLISTED SPECIAL DERMATOLOGICAL SERVICE OR PROCEDURE					
997	Manipulation Therapy		S	.69	$34.96	$7.23	$6.99
997	97250	MYOFASCIAL RELEASE/SOFT TISSUE MOBILIZATION, ONE OR MORE REGIONS					
997	97260	MANIPULATION (CERVICAL, THORACIC, LUMBOSACRAL, SACROILIAC, HAND, WRIST) (SEPARATE PROCEDURE), PERFORMED BY PHYSICIAN; ONE AREA					
997	97261	MANIPULATION (CERVICAL, THORACIC, LUMBOSACRAL, SACROILIAC, HAND, WRIST) (SEPARATE PROCEDURE), PERFORMED BY PHYSICIAN; EACH ADDITIONAL AREA					
997	98925	OSTEOPATHIC MANIPULATIVE TREATMENT (OMT); ONE TO TWO BODY REGIONS INVOLVED					
997	98926	OSTEOPATHIC MANIPULATIVE TREATMENT (OMT); THREE TO FOUR BODY REGIONS INVOLVED					
997	98927	OSTEOPATHIC MANIPULATIVE TREATMENT (OMT); FIVE TO SIX BODY REGIONS INVOLVED					
997	98928	OSTEOPATHIC MANIPULATIVE TREATMENT (OMT); SEVEN TO EIGHT BODY REGIONS INVOLVED					
997	98929	OSTEOPATHIC MANIPULATIVE TREATMENT (OMT); NINE TO TEN BODY REGIONS INVOLVED					
997	98940	CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); SPINAL, ONE TO TWO REGIONS					
997	98941	CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); SPINAL, THREE TO FOUR REGIONS					
997	98942	CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); SPINAL, FIVE REGIONS					
999	Therapeutic Phlebotomy		X	.43	$21.79	$10.85	$4.36
999	99195	PHLEBOTOMY, THERAPEUTIC (SEPARATE PROCEDURE)					

ADDENDUM D.—SUMMARY OF MEDICAL APCS

APC	CPT[1] HCPCS[2]	Description
911 Low Level Clinic Visits		
	99201	Office/outpatient visit, new
	99202	Office/outpatient visit, new
	99211	Office/outpatient visit, est
	99212	Office/outpatient visit, est
	99241	Office consultation
	99242	Office consultation
	99271	Confirmatory consultation
	99272	Confirmatory consultation
	G0101	Cancer Screening Exam, Women
913 Mid Level Clinic Visits		
	92002	Eye exam, new patient
	92012	Eye exam established pt
	99203	Office/outpatient visit, new
	99213	Office/outpatient visit, est
	99243	Office consultation
	99273	Confirmatory consultation
915 High Level Clinic Visits		
	92004	Eye exam, new patient
	92014	Eye exam & treatment
	92506	Speech & hearing evaluation
	99204	Office/outpatient visit, new
	99205	Office/outpatient visit, new
	99214	Office/outpatient visit, est
	99215	Office/outpatient visit, est
	99244	Office consultation
	99245	Office consultation
	99274	Confirmatory consultation
	99275	Confirmatory consultation
951 Low Level Emergency Visits		
	99281	Emergency dept visit
	99282	Emergency dept visit
953 Mid Level Emergency Visits		
	99283	Emergency dept visit
955 High Level Emergency Visits		
	99284	Emergency dept visit
	99285	Emergency dept visit

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Note: Medical visit APCs are created by combining level of visit from Addendum D with reason for visit from Addendum E. Thus a midlevel clinic visit (99203) for an eye disorder groups to APC 91368.

ADDENDUM E.—MAJOR DIAGNOSTIC CATEGORIES (MDCS)

MDC	Description
11	Well care and administrative
18	Skin and breast diseases
24	Musculoskeletal diseases
31	Ear, nose, mouth and throat diseases
33	Respiratory system diseases
36	Cardiovascular system diseases
41	Digestive system diseases
53	Kidney, urinary tract and male genital diseases
56	Female genital system diseases
57	Pregnancy and Neonatal Care
63	Nervous System Diseases
68	Eye Diseases
72	Trauma and poisoning
78	Major signs, symptoms and findings
82	Endocrine, nutritional and metabolic diseases
86	Immunologic and hematologic diseases
88	Malignancy
91	Psychiatric Disorders
97	Infectious disease
99	Unknown cause of mortality

ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCS) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS

ICD–9	ICD–9 Description	MDC
0010	CHOLERA D/T VIB CHOLERAE	41
0011	CHOLERA D/T VIB EL TOR	41
0019	CHOLERA NOS	41

*ICD–9 Codes preceded by an asterisk are codes that are not valid as a reason for the visit.

ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
0020	TYPHOID FEVER	97
0021	PARATYPHOID FEVER A	97
0022	PARATYPHOID FEVER B	97
0023	PARATYPHOID FEVER C	97
0029	PARATYPHOID FEVER NOS	97
0030	SALMONELLA ENTERITIS	41
0031	SALMONELLA SEPTICEMIA	97
00320	LOCAL SALMONELLA INF NOS	97
00321	SALMONELLA MENINGITIS	97
00322	SALMONELLA PNEUMONIA	33
00323	SALMONELLA ARTHRITIS	24
00324	SALMONELLA OSTEOMYELITIS	24
00329	LOCAL SALMONELLA INF NEC	97
0038	SALMONELLA INFECTION NEC	97
0039	SALMONELLA INFECTION NOS	97
0040	SHIGELLA DYSENTERIAE	41
0041	SHIGELLA FLEXNERI	41
0042	SHIGELLA BOYDII	41
0043	SHIGELLA SONNEI	41
0048	SHIGELLA INFECTION NEC	41
0049	SHIGELLOSIS NOS	41
0050	STAPH FOOD POISONING	41
0051	BOTULISM	97
0052	FOOD POIS D/T C. PERFRIN	41
0053	FOOD POIS: CLOSTRID NEC	41
0054	FOOD POIS: V. PARAHAEM	41
00581	FOOD POISN D/T V. VULNIF	41
00589	BACT FOOD POISONING NEC	41
0059	FOOD POISONING NOS	41
0060	AC AMEBIASIS W/O ABSCESS	41
0061	CHR AMEBIASIS W/O ABSCES	41
0062	AMEBIC NONDYSENT COLITIS	41
0063	AMEBIC LIVER ABSCESS	41
0064	AMEBIC LUNG ABSCESS	33
0065	AMEBIC BRAIN ABSCESS	97
0066	AMEBIC SKIN ULCERATION	18
0068	AMEBIC INFECTION NEC	97
0069	AMEBIASIS NOS	97
0070	BALANTIDIASIS	41
0071	GIARDIASIS	41
0072	COCCIDIOSIS	41
0073	INTEST TRICHOMONIASIS	41
0078	PROTOZOAL INTEST DIS NEC	41
0079	PROTOZOAL INTEST DIS NOS	41
00800	INTEST INFEC E COLI NOS	41
00801	INT INF E COLI ENTRPATH	41
00802	INT INF E COLI ENTRTOXGN	41
00803	INT INF E COLI ENTRNVSV	41
00804	INT INF E COLI ENTRHMRG	41
00809	INT INF E COLI SPCF NEC	41
0081	ARIZONA ENTERITIS	41
0082	AEROBACTER ENTERITIS	41
0083	PROTEUS ENTERITIS	41
00841	STAPHYLOCOCC ENTERITIS	41
00842	PSEUDOMONAS ENTERITIS	41
00843	INT INFEC CAMPYLOBACTER	41
00844	INT INF YRSNIA ENTRCLTCA	41
00845	INT INF CLSTRDIUM DFCILE	41
00846	INTES INFEC OTH ANEROBES	41
00847	INT INF OTH GRM NEG BCTR	41
00849	BACTERIAL ENTERITIS NEC	41
0085	BACTERIAL ENTERITIS NOS	41
00861	INTES INFEC ROTAVIRUS	41
00862	INTES INFEC ADENOVIRUS	41
00863	INT INF NORWALK VIRUS	41
00864	INT INF OTH SML RND VRUS	41
00865	INTES INFEC CALCIVIRUS	41
00866	INTES INFEC ASTROVIRUS	41
00867	INT INF ENTEROVIRUS NEC	41
00869	OTHER VIRAL INTES INFEC	41
0088	VIRAL ENTERITIS NOS	41
0090	INFECTIOUS ENTERITIS NOS	41
0091	ENTERITIS OF INFECT ORIG	41
0092	INFECTIOUS DIARRHEA NOS	41
0093	DIARRHEA OF INFECT ORIG	41
01000	PRIM TB COMPLEX-UNSPEC	33

*ICD–9 Codes preceded by an asterisk are codes that are not valid as a reason for the visit.

ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
01001	PRIM TB COMPLEX-NO EXAM	33
01002	PRIM TB COMPLEX-EXM UNKN	33
01003	PRIM TB COMPLEX-MICRO DX	33
01004	PRIM TB COMPLEX-CULT DX	33
01005	PRIM TB COMPLEX-HISTO DX	33
01006	PRIM TB COMPLEX-OTH TEST	33
01010	PRIM TB PLEURISY-UNSPEC	33
01011	PRIM TB PLEURISY-NO EXAM	33
01012	PRIM TB PLEUR-EXAM UNKN	33
01013	PRIM TB PLEURIS-MICRO DX	33
01014	PRIM TB PLEURISY-CULT DX	33
01015	PRIM TB PLEURIS-HISTO DX	33
01016	PRIM TB PLEURIS-OTH TEST	33
01080	PRIM PROG TB NEC-UNSPEC	33
01081	PRIM PROG TB NEC-NO EXAM	33
01082	PRIM PR TB NEC-EXAM UNKN	33
01083	PRIM PRG TB NEC-MICRO DX	33
01084	PRIM PROG TB NEC-CULT DX	33
01085	PRIM PRG TB NEC-HISTO DX	33
01086	PRIM PRG TB NEC-OTH TEST	33
01090	PRIMARY TB NOS-UNSPEC	33
01091	PRIMARY TB NOS-NO EXAM	33
01092	PRIMARY TB NOS-EXAM UNKN	33
01093	PRIMARY TB NOS-MICRO DX	33
01094	PRIMARY TB NOS-CULT DX	33
01095	PRIMARY TB NOS-HISTO DX	33
01096	PRIMARY TB NOS-OTH TEST	33
01100	TB LUNG INFILTR-UNSPEC	33
01101	TB LUNG INFILTR-NO EXAM	33
01102	TB LUNG INFILTR-EXM UNKN	33
01103	TB LUNG INFILTR-MICRO DX	33
01104	TB LUNG INFILTR-CULT DX	33
01105	TB LUNG INFILTR-HISTO DX	33
01106	TB LUNG INFILTR-OTH TEST	33
01110	TB LUNG NODULAR-UNSPEC	33
01111	TB LUNG NODULAR-NO EXAM	33
01112	TB LUNG NODUL-EXAM UNKN	33
01113	TB LUNG NODULAR-MICRO DX	33
01114	TB LUNG NODULAR-CULT DX	33
01115	TB LUNG NODULAR-HISTO DX	33
01116	TB LUNG NODULAR-OTH TEST	33
01120	TB LUNG W CAVITY-UNSPEC	33
01121	TB LUNG W CAVITY-NO EXAM	33
01122	TB LUNG CAVITY-EXAM UNKN	33
01123	TB LUNG W CAVIT-MICRO DX	33
01124	TB LUNG W CAVITY-CULT DX	33
01125	TB LUNG W CAVIT-HISTO DX	33
01126	TB LUNG W CAVIT-OTH TEST	33
01130	TB OF BRONCHUS-UNSPEC	33
01131	TB OF BRONCHUS-NO EXAM	33
01132	TB OF BRONCHUS-EXAM UNKN	33
01133	TB OF BRONCHUS-MICRO DX	33
01134	TB OF BRONCHUS-CULT DX	33
01135	TB OF BRONCHUS-HISTO DX	33
01136	TB OF BRONCHUS-OTH TEST	33
01140	TB LUNG FIBROSIS-UNSPEC	33
01141	TB LUNG FIBROSIS-NO EXAM	33
01142	TB LUNG FIBROS-EXAM UNKN	33
01143	TB LUNG FIBROS-MICRO DX	33
01144	TB LUNG FIBROSIS-CULT DX	33
01145	TB LUNG FIBROS-HISTO DX	33
01146	TB LUNG FIBROS-OTH TEST	33
01150	TB BRONCHIECTASIS-UNSPEC	33
01151	TB BRONCHIECT-NO EXAM	33
01152	TB BRONCHIECT-EXAM UNKN	33
01153	TB BRONCHIECT-MICRO DX	33
01154	TB BRONCHIECT-CULT DX	33
01155	TB BRONCHIECT-HISTO DX	33
01156	TB BRONCHIECT-OTH TEST	33
01160	TB PNEUMONIA-UNSPEC	33
01161	TB PNEUMONIA-NO EXAM	33
01162	TB PNEUMONIA-EXAM UNKN	33
01163	TB PNEUMONIA-MICRO DX	33
01164	TB PNEUMONIA-CULT DX	33
01165	TB PNEUMONIA-HISTO DX	33
01166	TB PNEUMONIA-OTH TEST	33

*ICD–9 Codes preceded by an asterisk are codes that are not valid as a reason for the visit.

ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
01170	TB PNEUMOTHORAX-UNSPEC	33
01171	TB PNEUMOTHORAX-NO EXAM	33
01172	TB PNEUMOTHORX-EXAM UNKN	33
01173	TB PNEUMOTHORAX-MICRO DX	33
01174	TB PNEUMOTHORAX-CULT DX	33
01175	TB PNEUMOTHORAX-HISTO DX	33
01176	TB PNEUMOTHORAX-OTH TEST	33
01180	PULMONARY TB NEC-UNSPEC	33
01181	PULMONARY TB NEC-NO EXAM	33
01182	PULMON TB NEC-EXAM UNKN	33
01183	PULMON TB NEC-MICRO DX	33
01184	PULMON TB NEC-CULT DX	33
01185	PULMON TB NEC-HISTO DX	33
01186	PULMON TB NEC-OTH TEST	33
01190	PULMONARY TB NOS-UNSPEC	33
01191	PULMONARY TB NOS-NO EXAM	33
01192	PULMON TB NOS-EXAM UNKN	33
01193	PULMON TB NOS-MICRO DX	33
01194	PULMON TB NOS-CULT DX	33
01195	PULMON TB NOS-HISTO DX	33
01196	PULMON TB NOS-OTH TEST	33
01200	TB PLEURISY-UNSPEC	33
01201	TB PLEURISY-NO EXAM	33
01202	TB PLEURISY-EXAM UNKN	33
01203	TB PLEURISY-MICRO DX	33
01204	TB PLEURISY-CULT DX	33
01205	TB PLEURISY-HISTOLOG DX	33
01206	TB PLEURISY-OTH TEST	33
01210	TB THORACIC NODES-UNSPEC	33
01211	TB THORAX NODE-NO EXAM	33
01212	TB THORAX NODE-EXAM UNKN	33
01213	TB THORAX NODE-MICRO DX	33
01214	TB THORAX NODE-CULT DX	33
01215	TB THORAX NODE-HISTO DX	33
01216	TB THORAX NODE-OTH TEST	33
01220	ISOL TRACHEAL TB-UNSPEC	31
01221	ISOL TRACHEAL TB-NO EXAM	31
01222	ISOL TRACH TB-EXAM UNKN	31
01223	ISOLAT TRACH TB-MICRO DX	31
01224	ISOL TRACHEAL TB-CULT DX	31
01225	ISOLAT TRACH TB-HISTO DX	31
01226	ISOLAT TRACH TB-OTH TEST	31
01230	TB LARYNGITIS-UNSPEC	31
01231	TB LARYNGITIS-NO EXAM	31
01232	TB LARYNGITIS-EXAM UNKN	31
01233	TB LARYNGITIS-MICRO DX	31
01234	TB LARYNGITIS-CULT DX	31
01235	TB LARYNGITIS-HISTO DX	31
01236	TB LARYNGITIS-OTH TEST	31
01280	RESP TB NEC-UNSPEC	33
01281	RESP TB NEC-NO EXAM	33
01282	RESP TB NEC-EXAM UNKN	33
01283	RESP TB NEC-MICRO DX	33
01284	RESP TB NEC-CULT DX	33
01285	RESP TB NEC-HISTO DX	33
01286	RESP TB NEC-OTH TEST	33
01300	TB MENINGITIS-UNSPEC	63
01301	TB MENINGITIS-NO EXAM	63
01302	TB MENINGITIS-EXAM UNKN	63
01303	TB MENINGITIS-MICRO DX	63
01304	TB MENINGITIS-CULT DX	63
01305	TB MENINGITIS-HISTO DX	63
01306	TB MENINGITIS-OTH TEST	63
01310	TUBRCLMA MENINGES-UNSPEC	63
01311	TUBRCLMA MENING-NO EXAM	63
01312	TUBRCLMA MENIN-EXAM UNKN	63
01313	TUBRCLMA MENING-MICRO DX	63
01314	TUBRCLMA MENING-CULT DX	63
01315	TUBRCLMA MENING-HISTO DX	63
01316	TUBRCLMA MENING-OTH TEST	63
01320	TUBERCULOMA BRAIN-UNSPEC	63
01321	TUBRCLOMA BRAIN-NO EXAM	63
01322	TUBRCLMA BRAIN-EXAM UNKN	63
01323	TUBRCLOMA BRAIN-MICRO DX	63
01324	TUBRCLOMA BRAIN-CULT DX	63
01325	TUBRCLOMA BRAIN-HISTO DX	63

*ICD–9 Codes preceded by an asterisk are codes that are not valid as a reason for the visit.

ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
01326	TUBRCLOMA BRAIN-OTH TEST	63
01330	TB BRAIN ABSCESS-UNSPEC	63
01331	TB BRAIN ABSCESS-NO EXAM	63
01332	TB BRAIN ABSC-EXAM UNKN	63
01333	TB BRAIN ABSC-MICRO DX	63
01334	TB BRAIN ABSCESS-CULT DX	63
01335	TB BRAIN ABSC-HISTO DX	63
01336	TB BRAIN ABSC-OTH TEST	63
01340	TUBRCLMA SP CORD-UNSPEC	63
01341	TUBRCLMA SP CORD-NO EXAM	63
01342	TUBRCLMA SP CD-EXAM UNKN	63
01343	TUBRCLMA SP CRD-MICRO DX	63
01344	TUBRCLMA SP CORD-CULT DX	63
01345	TUBRCLMA SP CRD-HISTO DX	63
01346	TUBRCLMA SP CRD-OTH TEST	63
01350	TB SP CRD ABSCESS-UNSPEC	63
01351	TB SP CRD ABSC-NO EXAM	63
01352	TB SP CRD ABSC-EXAM UNKN	63
01353	TB SP CRD ABSC-MICRO DX	63
01354	TB SP CRD ABSC-CULT DX	63
01355	TB SP CRD ABSC-HISTO DX	63
01356	TB SP CRD ABSC-OTH TEST	63
01360	TB ENCEPHALITIS-UNSPEC	63
01361	TB ENCEPHALITIS-NO EXAM	63
01362	TB ENCEPHALIT-EXAM UNKN	63
01363	TB ENCEPHALITIS-MICRO DX	63
01364	TB ENCEPHALITIS-CULT DX	63
01365	TB ENCEPHALITIS-HISTO DX	63
01366	TB ENCEPHALITIS-OTH TEST	63
01380	CNS TB NEC-UNSPEC	63
01381	CNS TB NEC-NO EXAM	63
01382	CNS TB NEC-EXAM UNKN	63
01383	CNS TB NEC-MICRO DX	63
01384	CNS TB NEC-CULT DX	63
01385	CNS TB NEC-HISTO DX	63
01386	CNS TB NEC-OTH TEST	63
01390	CNS TB NOS-UNSPEC	63
01391	CNS TB NOS-NO EXAM	63
01392	CNS TB NOS-EXAM UNKN	63
01393	CNS TB NOS-MICRO DX	63
01394	CNS TB NOS-CULT DX	63
01395	CNS TB NOS-HISTO DX	63
01396	CNS TB NOS-OTH TEST	63
01400	TB PERITONITIS-UNSPEC	41
01401	TB PERITONITIS-NO EXAM	41
01402	TB PERITONITIS-EXAM UNKN	41
01403	TB PERITONITIS-MICRO DX	41
01404	TB PERITONITIS-CULT DX	41
01405	TB PERITONITIS-HISTO DX	41
01406	TB PERITONITIS-OTH TEST	41
01480	INTESTINAL TB NEC-UNSPEC	41
01481	INTESTIN TB NEC-NO EXAM	41
01482	INTEST TB NEC-EXAM UNKN	41
01483	INTESTIN TB NEC-MICRO DX	41
01484	INTESTIN TB NEC-CULT DX	41
01485	INTESTIN TB NEC-HISTO DX	41
01486	INTESTIN TB NEC-OTH TEST	41
01500	TB OF VERTEBRA-UNSPEC	24
01501	TB OF VERTEBRA-NO EXAM	24
01502	TB OF VERTEBRA-EXAM UNKN	24
01503	TB OF VERTEBRA-MICRO DX	24
01504	TB OF VERTEBRA-CULT DX	24
01505	TB OF VERTEBRA-HISTO DX	24
01506	TB OF VERTEBRA-OTH TEST	24
01510	TB OF HIP-UNSPEC	24
01511	TB OF HIP-NO EXAM	24
01512	TB OF HIP-EXAM UNKN	24
01513	TB OF HIP-MICRO DX	24
01514	TB OF HIP-CULT DX	24
01515	TB OF HIP-HISTO DX	24
01516	TB OF HIP-OTH TEST	24
01520	TB OF KNEE-UNSPEC	24
01521	TB OF KNEE-NO EXAM	24
01522	TB OF KNEE-EXAM UNKN	24
01523	TB OF KNEE-MICRO DX	24
01524	TB OF KNEE-CULT DX	24

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
01525	TB OF KNEE-HISTO DX	24
01526	TB OF KNEE-OTH TEST	24
01550	TB OF LIMB BONES-UNSPEC	24
01551	TB LIMB BONES-NO EXAM	24
01552	TB LIMB BONES-EXAM UNKN	24
01553	TB LIMB BONES-MICRO DX	24
01554	TB LIMB BONES-CULT DX	24
01555	TB LIMB BONES-HISTO DX	24
01556	TB LIMB BONES-OTH TEST	24
01560	TB OF MASTOID-UNSPEC	31
01561	TB OF MASTOID-NO EXAM	31
01562	TB OF MASTOID-EXAM UNKN	31
01563	TB OF MASTOID-MICRO DX	31
01564	TB OF MASTOID-CULT DX	31
01565	TB OF MASTOID-HISTO DX	31
01566	TB OF MASTOID-OTH TEST	31
01570	TB OF BONE NEC-UNSPEC	24
01571	TB OF BONE NEC-NO EXAM	24
01572	TB OF BONE NEC-EXAM UNKN	24
01573	TB OF BONE NEC-MICRO DX	24
01574	TB OF BONE NEC-CULT DX	24
01575	TB OF BONE NEC-HISTO DX	24
01576	TB OF BONE NEC-OTH TEST	24
01580	TB OF JOINT NEC-UNSPEC	24
01581	TB OF JOINT NEC-NO EXAM	24
01582	TB JOINT NEC-EXAM UNKN	24
01583	TB OF JOINT NEC-MICRO DX	24
01584	TB OF JOINT NEC-CULT DX	24
01585	TB OF JOINT NEC-HISTO DX	24
01586	TB OF JOINT NEC-OTH TEST	24
01590	TB BONE/JOINT NOS-UNSPEC	24
01591	TB BONE/JT NOS-NO EXAM	24
01592	TB BONE/JT NOS-EXAM UNKN	24
01593	TB BONE/JT NOS-MICRO DX	24
01594	TB BONE/JT NOS-CULT DX	24
01595	TB BONE/JT NOS-HISTO DX	24
01596	TB BONE/JT NOS-OTH TEST	24
01600	TB OF KIDNEY-UNSPEC	53
01601	TB OF KIDNEY-NO EXAM	53
01602	TB OF KIDNEY-EXAM UNKN	53
01603	TB OF KIDNEY-MICRO DX	53
01604	TB OF KIDNEY-CULT DX	53
01605	TB OF KIDNEY-HISTO DX	53
01606	TB OF KIDNEY-OTH TEST	53
01610	TB OF BLADDER-UNSPEC	53
01611	TB OF BLADDER-NO EXAM	53
01612	TB OF BLADDER-EXAM UNKN	53
01613	TB OF BLADDER-MICRO DX	53
01614	TB OF BLADDER-CULT DX	53
01615	TB OF BLADDER-HISTO DX	53
01616	TB OF BLADDER-OTH TEST	53
01620	TB OF URETER-UNSPEC	53
01621	TB OF URETER-NO EXAM	53
01622	TB OF URETER-EXAM UNKN	53
01623	TB OF URETER-MICRO DX	53
01624	TB OF URETER-CULT DX	53
01625	TB OF URETER-HISTO DX	53
01626	TB OF URETER-OTH TEST	53
01630	TB URINARY NEC-UNSPEC	53
01631	TB URINARY NEC-NO EXAM	53
01632	TB URINARY NEC-EXAM UNKN	53
01633	TB URINARY NEC-MICRO DX	53
01634	TB URINARY NEC-CULT DX	53
01635	TB URINARY NEC-HISTO DX	53
01636	TB URINARY NEC-OTH TEST	53
01640	TB EPIDIDYMIS-UNSPEC	53
01641	TB EPIDIDYMIS-NO EXAM	53
01642	TB EPIDIDYMIS-EXAM UNKN	53
01643	TB EPIDIDYMIS-MICRO DX	53
01644	TB EPIDIDYMIS-CULT DX	53
01645	TB EPIDIDYMIS-HISTO DX	53
01646	TB EPIDIDYMIS-OTH TEST	53
01650	TB MALE GENIT NEC-UNSPEC	53
01651	TB MALE GEN NEC-NO EXAM	53
01652	TB MALE GEN NEC-EX UNKN	53
01653	TB MALE GEN NEC-MICRO DX	53

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
01654	TB MALE GEN NEC-CULT DX	53
01655	TB MALE GEN NEC-HISTO DX	53
01656	TB MALE GEN NEC-OTH TEST	53
01660	TB OVARY & TUBE-UNSPEC	56
01661	TB OVARY & TUBE-NO EXAM	56
01662	TB OVARY/TUBE-EXAM UNKN	56
01663	TB OVARY & TUBE-MICRO DX	56
01664	TB OVARY & TUBE-CULT DX	56
01665	TB OVARY & TUBE-HISTO DX	56
01666	TB OVARY & TUBE-OTH TEST	56
01670	TB FEMALE GEN NEC-UNSPEC	56
01671	TB FEM GEN NEC-NO EXAM	56
01672	TB FEM GEN NEC-EXAM UNKN	56
01673	TB FEM GEN NEC-MICRO DX	56
01674	TB FEM GEN NEC-CULT DX	56
01675	TB FEM GEN NEC-HISTO DX	56
01676	TB FEM GEN NEC-OTH TEST	56
01690	GU TB NOS-UNSPEC	53
01691	GU TB NOS-NO EXAM	53
01692	GU TB NOS-EXAM UNKN	53
01693	GU TB NOS-MICRO DX	53
01694	GU TB NOS-CULT DX	53
01695	GU TB NOS-HISTO DX	53
01696	GU TB NOS-OTH TEST	53
01700	TB SKIN/SUBCUTAN-UNSPEC	18
01701	TB SKIN/SUBCUT-NO EXAM	18
01702	TB SKIN/SUBCUT-EXAM UNKN	18
01703	TB SKIN/SUBCUT-MICRO DX	18
01704	TB SKIN/SUBCUT-CULT DX	18
01705	TB SKIN/SUBCUT-HISTO DX	18
01706	TB SKIN/SUBCUT-OTH TEST	18
01710	ERYTHEMA NODOS TB-UNSPEC	18
01711	ERYTHEM NODOS TB-NO EXAM	18
01712	ERYTHEM NOD TB-EXAM UNKN	18
01713	ERYTHEM NOD TB-MICRO DX	18
01714	ERYTHEM NODOS TB-CULT DX	18
01715	ERYTHEM NOD TB-HISTO DX	18
01716	ERYTHEM NOD TB-OTH TEST	18
01720	TB PERIPH LYMPH-UNSPEC	86
01721	TB PERIPH LYMPH-NO EXAM	86
01722	TB PERIPH LYMPH-EXAM UNK	86
01723	TB PERIPH LYMPH-MICRO DX	86
01724	TB PERIPH LYMPH-CULT DX	86
01725	TB PERIPH LYMPH-HISTO DX	86
01726	TB PERIPH LYMPH-OTH TEST	86
01730	TB OF EYE-UNSPEC	68
01731	TB OF EYE-NO EXAM	68
01732	TB OF EYE-EXAM UNKN	68
01733	TB OF EYE-MICRO DX	68
01734	TB OF EYE-CULT DX	68
01735	TB OF EYE-HISTO DX	68
01736	TB OF EYE-OTH TEST	68
01740	TB OF EAR-UNSPEC	31
01741	TB OF EAR-NO EXAM	31
01742	TB OF EAR-EXAM UNKN	31
01743	TB OF EAR-MICRO DX	31
01744	TB OF EAR-CULT DX	31
01745	TB OF EAR-HISTO DX	31
01746	TB OF EAR-OTH TEST	31
01750	TB OF THYROID-UNSPEC	82
01751	TB OF THYROID-NO EXAM	82
01752	TB OF THYROID-EXAM UNKN	82
01753	TB OF THYROID-MICRO DX	82
01754	TB OF THYROID-CULT DX	82
01755	TB OF THYROID-HISTO DX	82
01756	TB OF THYROID-OTH TEST	82
01760	TB OF ADRENAL-UNSPEC	82
01761	TB OF ADRENAL-NO EXAM	82
01762	TB OF ADRENAL-EXAM UNKN	82
01763	TB OF ADRENAL-MICRO DX	82
01764	TB OF ADRENAL-CULT DX	82
01765	TB OF ADRENAL-HISTO DX	82
01766	TB OF ADRENAL-OTH TEST	82
01770	TB OF SPLEEN-UNSPEC	86
01771	TB OF SPLEEN-NO EXAM	86
01772	TB OF SPLEEN-EXAM UNKN	86

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
01773	TB OF SPLEEN-MICRO DX	86
01774	TB OF SPLEEN-CULT DX	86
01775	TB OF SPLEEN-HISTO DX	86
01776	TB OF SPLEEN-OTH TEST	86
01780	TB ESOPHAGUS-UNSPEC	41
01781	TB ESOPHAGUS-NO EXAM	41
01782	TB ESOPHAGUS-EXAM UNKN	41
01783	TB ESOPHAGUS-MICRO DX	41
01784	TB ESOPHAGUS-CULT DX	41
01785	TB ESOPHAGUS-HISTO DX	41
01786	TB ESOPHAGUS-OTH TEST	41
01790	TB OF ORGAN NEC-UNSPEC	97
01791	TB OF ORGAN NEC-NO EXAM	97
01792	TB ORGAN NEC-EXAM UNKN	97
01793	TB OF ORGAN NEC-MICRO DX	97
01794	TB OF ORGAN NEC-CULT DX	97
01795	TB OF ORGAN NEC-HISTO DX	97
01796	TB OF ORGAN NEC-OTH TEST	97
01800	ACUTE MILIARY TB-UNSPEC	97
01801	ACUTE MILIARY TB-NO EXAM	97
01802	AC MILIARY TB-EXAM UNKN	97
01803	AC MILIARY TB-MICRO DX	97
01804	ACUTE MILIARY TB-CULT DX	97
01805	AC MILIARY TB-HISTO DX	97
01806	AC MILIARY TB-OTH TEST	97
01880	MILIARY TB NEC-UNSPEC	97
01881	MILIARY TB NEC-NO EXAM	97
01882	MILIARY TB NEC-EXAM UNKN	97
01883	MILIARY TB NEC-MICRO DX	97
01884	MILIARY TB NEC-CULT DX	97
01885	MILIARY TB NEC-HISTO DX	97
01886	MILIARY TB NEC-OTH TEST	97
01890	MILIARY TB NOS-UNSPEC	97
01891	MILIARY TB NOS-NO EXAM	97
01892	MILIARY TB NOS-EXAM UNKN	97
01893	MILIARY TB NOS-MICRO DX	97
01894	MILIARY TB NOS-CULT DX	97
01895	MILIARY TB NOS-HISTO DX	97
01896	MILIARY TB NOS-OTH TEST	97
0200	BUBONIC PLAGUE	97
0201	CELLULOCUTANEOUS PLAGUE	97
0202	SEPTICEMIC PLAGUE	97
0203	PRIMARY PNEUMONIC PLAGUE	33
0204	SECONDARY PNEUMON PLAGUE	33
0205	PNEUMONIC PLAGUE NOS	33
0208	OTHER TYPES OF PLAGUE	97
0209	PLAGUE NOS	97
0210	ULCEROGLANDUL TULAREMIA	97
0211	ENTERIC TULAREMIA	41
0212	PULMONARY TULAREMIA	33
0213	OCULOGLANDULAR TULAREMIA	97
0218	TULAREMIA NEC	97
0219	TULAREMIA NOS	97
0220	CUTANEOUS ANTHRAX	18
0221	PULMONARY ANTHRAX	33
0222	GASTROINTESTINAL ANTHRAX	41
0223	ANTHRAX SEPTICEMIA	97
0228	OTHER ANTHRAX MANIFEST	97
0229	ANTHRAX NOS	97
0230	BRUCELLA MELITENSIS	97
0231	BRUCELLA ABORTUS	97
0232	BRUCELLA SUIS	97
0233	BRUCELLA CANIS	97
0238	BRUCELLOSIS NEC	97
0239	BRUCELLOSIS NOS	97
024	GLANDERS	97
025	MELIOIDOSIS	97
0260	SPIRILLARY FEVER	97
0261	STREPTOBACILLARY FEVER	97
0269	RAT-BITE FEVER NOS	97
0270	LISTERIOSIS	97
0271	ERYSIPELOTHRIX INFECTION	97
0272	PASTEURELLOSIS	97
0278	ZOONOTIC BACT DIS NEC	97
0279	ZOONOTIC BACT DIS NOS	97
0300	LEPROMATOUS LEPROSY	97

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
0301	TUBERCULOID LEPROSY	97
0302	INDETERMINATE LEPROSY	97
0303	BORDERLINE LEPROSY	97
0308	LEPROSY NEC	97
0309	LEPROSY NOS	97
0310	PULMONARY MYCOBACTERIA	33
0311	CUTANEOUS MYCOBACTERIA	18
0318	MYCOBACTERIAL DIS NEC	97
0319	MYCOBACTERIAL DIS NOS	97
0320	FAUCIAL DIPHTHERIA	31
0321	NASOPHARYNX DIPHTHERIA	31
0322	ANT NASAL DIPHTHERIA	31
0323	LARYNGEAL DIPHTHERIA	31
03281	CONJUNCTIVAL DIPHTHERIA	68
03282	DIPHTHERITIC MYOCARDITIS	36
03283	DIPHTHERITIC PERITONITIS	41
03284	DIPHTHERITIC CYSTITIS	53
03285	CUTANEOUS DIPHTHERIA	18
03289	DIPHTHERIA NEC	97
0329	DIPHTHERIA NOS	97
0330	BORDETELLA PERTUSSIS	33
0331	BORDETELLA PARAPERTUSSIS	33
0338	WHOOPING COUGH NEC	33
0339	WHOOPING COUGH NOS	33
0340	STREP SORE THROAT	31
0341	SCARLET FEVER	97
035	ERYSIPELAS	18
0360	MENINGOCOCCAL MENINGITIS	63
0361	MENINGOCOCC ENCEPHALITIS	63
0362	MENINGOCOCCEMIA	97
0363	MENINGOCOCC ADRENAL SYND	97
03640	MENINGOCOCC CARDITIS NOS	36
03641	MENINGOCOCC PERICARDITIS	36
03642	MENINGOCOCC ENDOCARDITIS	36
03643	MENINGOCOCC MYOCARDITIS	36
03681	MENINGOCOCC OPTIC NEURIT	68
03682	MENINGOCOCC ARTHROPATHY	24
03689	MENINGOCOCCAL INFECT NEC	97
0369	MENINGOCOCCAL INFECT NOS	97
037	TETANUS	97
0380	STREPTOCOCCAL SEPTICEMIA	97
0382	PNEUMOCOCCAL SEPTICEMIA	97
0383	ANAEROBIC SEPTICEMIA	97
03840	GRAM-NEG SEPTICEMIA NOS	97
03841	H. INFLUENAE SEPTICEMIA	97
03842	E COLI SEPTICEMIA	97
03843	PSEUDOMONAS SEPTICEMIA	97
03844	SERRATIA SEPTICEMIA	97
03849	GRAM-NEG SEPTICEMIA NEC	97
0388	SEPTICEMIA NEC	97
0389	SEPTICEMIA NOS	97
0390	CUTANEOUS ACTINOMYCOSIS	18
0391	PULMONARY ACTINOMYCOSIS	33
0392	ABDOMINAL ACTINOMYCOSIS	41
0393	CERVICOFAC ACTINOMYCOSIS	18
0394	MADURA FOOT	18
0398	ACTINOMYCOSIS NEC	97
0399	ACTINOMYCOSIS NOS	97
0400	GAS GANGRENE	97
0401	RHINOSCLEROMA	97
0402	WHIPPLE'S DISEASE	41
0403	NECROBACILLOSIS	97
04081	TROPICAL PYOMYOSITIS	24
04089	BACTERIAL DISEASES NEC	97
04100	STREPTOCOCCUS UNSPECF	97
04101	STREPTOCOCCUS GROUP A	97
04102	STREPTOCOCCUS GROUP B	97
04103	STREPTOCOCCUS GROUP C	97
04104	STREPTOCOCCUS GROUP D	97
04105	STREPTOCOCCUS GROUP G	97
04109	OTHER STREPTOCOCCUS	97
04110	STAPHYLOCOCCUS UNSPCFIED	97
04111	STAPHYLOCOCCUS AUREUS	97
04119	OTHER STAPHYLOCOCCUS	97
0412	PNEUMOCOCCUS INFECT NOS	97
0413	KLEBSIELLA INFECT NOS	97

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
0414	E. COLI INFECT NOS	97
0415	H. INFLUENZAE INFECT NOS	97
0416	PROTEUS INFECTION NOS	97
0417	PSEUDOMONAS INFECT NOS	97
04181	MYCOPLASMA	97
04182	BACILLUS FRAGILIS	97
04183	CLOSTRIDIUM PERFRINGENS	97
04184	OTHER ANAEROBES	97
04185	OTH GRAM NEGATV BACTERIA	97
04186	HELICOBACTER PYLORI	41
04189	OTH SPECF BACTERIA	97
0419	BACTERIAL INFECTION NOS	97
042	HUMAN IMMUNO VIRUS DIS	86
04500	AC BULBAR POLIO-TYPE NOS	63
04501	AC BULBAR POLIO-TYPE 1	63
04502	AC BULBAR POLIO-TYPE 2	63
04503	AC BULBAR POLIO-TYPE 3	63
04510	PARAL POLIO NEC-TYPE NOS	63
04511	PARAL POLIO NEC-TYPE 1	63
04512	PARAL POLIO NEC-TYPE 2	63
04513	PARAL POLIO NEC-TYPE 3	63
04520	NONPARALY POLIO-TYPE NOS	63
04521	NONPARALYT POLIO-TYPE 1	63
04522	NONPARALYT POLIO-TYPE 2	63
04523	NONPARALYT POLIO-TYPE 3	63
04590	AC POLIO NOS-TYPE NOS	63
04591	AC POLIO NOS-TYPE 1	63
04592	AC POLIO NOS-TYPE 2	63
04593	AC POLIO NOS-TYPE 3	63
0460	KURU	63
0461	JAKOB-CREUTZFELDT DIS	63
0462	SUBAC SCLEROS PANENCEPH	63
0463	PROG MULTIFOC LEUKOENCEP	63
0468	CNS SLOW VIRUS INFEC NEC	63
0469	CNS SLOW VIRUS INFEC NOS	63
0470	COXSACKIE VIRUS MENING	63
0471	ECHO VIRUS MENINGITIS	63
0478	VIRAL MENINGITIS NEC	63
0479	VIRAL MENINGITIS NOS	63
048	OTH ENTEROVIRAL CNS DIS	97
0490	LYMPHOCYTIC CHORIOMENING	63
0491	ADENOVIRAL MENINGITIS	63
0498	VIRAL ENCEPHALITIS NEC	63
0499	VIRAL ENCEPHALITIS NOS	63
0500	VARIOLA MAJOR	97
0501	ALASTRIM	97
0502	MODIFIED SMALLPOX	97
0509	SMALLPOX NOS	97
0510	COWPOX	97
0511	PSEUDOCOWPOX	18
0512	CONTAGIOUS PUSTULAR DERM	18
0519	PARAVACCINIA NOS	97
0520	POSTVARICELLA ENCEPHALIT	63
0521	VARICELLA PNEUMONITIS	33
0527	VARICELLA COMPLICAT NEC	97
0528	VARICELLA COMPLICAT NOS	97
0529	VARICELLA UNCOMPLICATED	97
0530	HERPES ZOSTER MENINGITIS	63
05310	H ZOSTER NERV SYST NOS	63
05311	GENICULATE HERPES ZOSTER	63
05312	POSTHERPES TRIGEM NEURAL	63
05313	POSTHERPES POLYNEUROPATH	63
05319	H ZOSTER NERV SYST NEC	63
05320	HERPES ZOSTER OF EYELID	68
05321	H ZOSTER KERATOCONJUNCT	68
05322	H ZOSTER IRIDOCYCLITIS	68
05329	HERPES ZOSTER OF EYE NEC	68
05371	H ZOSTER OTITIS EXTERNA	31
05379	H ZOSTER COMPLICATED NEC	97
0538	H ZOSTER COMPLICATED NOS	97
0539	HERPES ZOSTER NOS	18
0540	ECZEMA HERPETICUM	18
05410	GENITAL HERPES NOS	97
05411	HERPETIC VULVOVAGINITIS	97
05412	HERPETIC ULCER OF VULVA	97
05413	HERPETIC INFECT OF PENIS	97

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
05419	GENITAL HERPES NEC	97
0542	HERPETIC GINGIVOSTOMAT	31
0543	HERPETIC ENCEPHALITIS	63
05440	HERPES SIMPLEX EYE NOS	68
05441	HERPES SIMPLEX OF EYELID	68
05442	DENDRITIC KERATITIS	68
05443	H SIMPLEX KERATITIS	68
05444	H SIMPLEX IRIDOCYCLITIS	68
05449	HERPES SIMPLEX EYE NEC	68
0545	HERPETIC SEPTICEMIA	97
0546	HERPETIC WHITLOW	18
05471	VISCERAL HERPES SIMPLEX	41
05472	H SIMPLEX MENINGITIS	63
05473	H SIMPLEX OTITIS EXTERNA	31
05479	H SIMPLEX COMPLICAT NEC	97
0548	H SIMPLEX COMPLICAT NOS	97
0549	HERPES SIMPLEX NOS	18
0550	POSTMEASLES ENCEPHALITIS	63
0551	POSTMEASLES PNEUMONIA	33
0552	POSTMEASLES OTITIS MEDIA	31
05571	MEASLES KERATITIS	68
05579	MEASLES COMPLICATION NEC	97
0558	MEASLES COMPLICATION NOS	97
0559	MEASLES UNCOMPLICATED	97
05600	RUBELLA NERVE COMPL NOS	63
05601	RUBELLA ENCEPHALITIS	63
05609	RUBELLA NERVE COMPL NEC	63
05671	ARTHRITIS DUE TO RUBELLA	24
05679	RUBELLA COMPLICATION NEC	97
0568	RUBELLA COMPLICATION NOS	97
0569	RUBELLA UNCOMPLICATED	97
0570	ERYTHEMA INFECTIOSUM	97
0578	VIRAL EXANTHEMATA NEC	97
0579	VIRAL EXANTHEMATA NOS	97
0600	SYLVATIC YELLOW FEVER	97
0601	URBAN YELLOW FEVER	97
0609	YELLOW FEVER NOS	97
061	DENGUE	97
0620	JAPANESE ENCEPHALITIS	63
0621	WEST EQUINE ENCEPHALITIS	63
0622	EAST EQUINE ENCEPHALITIS	63
0623	ST LOUIS ENCEPHALITIS	63
0624	AUSTRALIAN ENCEPHALITIS	63
0625	CALIFORNIA ENCEPHALITIS	97
0628	MOSQUIT-BORNE ENCEPH NEC	97
0629	MOSQUIT-BORNE ENCEPH NOS	97
0630	RUSSIA SPR-SUMMER ENCEPH	97
0631	LOUPING ILL	97
0632	CENT EUROPE ENCEPHALITIS	63
0638	TICK-BORNE ENCEPH NEC	97
0639	TICK-BORNE ENCEPH NOS	97
064	VIR ENCEPH ARTHROPOD NEC	63
0650	CRIMEAN HEMORRHAGIC FEV	97
0651	OMSK HEMORRHAGIC FEVER	97
0652	KYASANUR FOREST DISEASE	97
0653	TICK-BORNE HEM FEVER NEC	97
0654	MOSQUITO-BORNE HEM FEVER	97
0658	ARTHROPOD HEM FEVER NEC	97
0659	ARTHROPOD HEM FEVER NOS	97
0660	PHLEBOTOMUS FEVER	97
0661	TICK-BORNE FEVER	97
0662	VENEZUELAN EQUINE FEVER	63
0663	MOSQUITO-BORNE FEVER NEC	97
0668	ARTHROPOD VIRUS NEC	97
0669	ARTHROPOD VIRUS NOS	97
0700	HEPATITIS A WITH COMA	78
0701	HEPATITIS A W/O COMA	41
07020	HPT B ACTE COMA WO DLTA	78
07021	HPT B ACTE COMA W DLTA	78
07022	HPT B CHRN COMA WO DLTA	78
07023	HPT B CHRN COMA W DLTA	78
07030	HPT B ACTE WO CM WO DLTA	41
07031	HPT B ACTE WO CM W DLTA	41
07032	HPT B CHRN WO CM WO DLTA	41
07033	HPT B CHRN WO CM W DLTA	41
07041	HPT C ACUTE W HEPAT COMA	78

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
07042	HPT DLT WO B W HPT COMA	78
07043	HPT E W HEPAT COMA	78
07044	CHRNC HPT C W HEPAT COMA	78
07049	OTH VRL HEPAT W HPT COMA	78
07051	HPT C ACUTE WO HPAT COMA	41
07052	HPT DLT WO B WO HPT COMA	41
07053	HPT E WO HEPAT COMA	41
07054	CHRNC HPT C WO HPAT COMA	41
07059	OTH VRL HPAT WO HPT COMA	41
0706	VIRAL HEPAT NOS W COMA	78
0709	VIRAL HEPAT NOS W/O COMA	41
071	RABIES	63
0720	MUMPS ORCHITIS	53
0721	MUMPS MENINGITIS	63
0722	MUMPS ENCEPHALITIS	63
0723	MUMPS PANCREATITIS	41
07271	MUMPS HEPATITIS	41
07272	MUMPS POLYNEUROPATHY	63
07279	MUMPS COMPLICATION NEC	97
0728	MUMPS COMPLICATION NOS	97
0729	MUMPS UNCOMPLICATED	97
0730	ORNITHOSIS PNEUMONIA	33
0737	ORNITHOSIS COMPLICAT NEC	97
0738	ORNITHOSIS COMPLICAT NOS	97
0739	ORNITHOSIS NOS	97
0740	HERPANGINA	31
0741	EPIDEMIC PLEURODYNIA	33
07420	COXSACKIE CARDITIS NOS	36
07421	COXSACKIE PERICARDITIS	36
07422	COXSACKIE ENDOCARDITIS	36
07423	COXSACKIE MYOCARDITIS	36
0743	HAND, FOOT & MOUTH DIS	97
0748	COXSACKIE VIRUS NEC	97
075	INFECTIOUS MONONUCLEOSIS	97
0760	TRACHOMA, INITIAL STAGE	68
0761	TRACHOMA, ACTIVE STAGE	68
0769	TRACHOMA NOS	68
0770	INCLUSION CONJUNCTIVITIS	68
0771	EPIDEM KERATOCONJUNCTIV	68
0772	PHARYNGOCONJUNCT FEVER	68
0773	ADENOVIRAL CONJUNCT NEC	68
0774	EPIDEM HEM CONJUNCTIVIT	68
0778	VIRAL CONJUNCTIVITIS NEC	68
07798	UNSP DS CONJUC CHLAMYDIA	97
07799	UNSP DS CONJUC VIRUSES	97
0780	MOLLUSCUM CONTAGIOSUM	18
07810	VIRAL WARTS NOS	97
07811	CONDYLOMA ACUMINATUM	97
07819	OTH SPECFD VIRAL WARTS	97
0782	SWEATING FEVER	97
0783	CAT-SCRATCH DISEASE	97
0784	FOOT & MOUTH DISEASE	97
0785	CYTOMEGALOVIRAL DISEASE	97
0786	HEM NEPHROSONEPHRITIS	53
0787	ARENAVIRAL HEM FEVER	97
07881	EPIDEMIC VERTIGO	31
07882	EPIDEMIC VOMITING SYND	41
07888	OTH SPEC DIS CHLAMYDIAE	97
07889	OTH SPEC DIS VIRUSES	97
0790	ADENOVIRUS INFECT NOS	97
0791	ECHO VIRUS INFECT NOS	97
0792	COXSACKIE VIRUS INF NOS	97
0793	RHINOVIRUS INFECT NOS	97
0794	HUMAN PAPILLOMA VIRUS	97
07950	RETROVIRUS, UNSPECIFIED	86
07951	HTLV-1 INFECTION OTH DIS	86
07952	HTLV-II INFECTN OTH DIS	86
07953	HIV-2 INFECTION OTH DIS	86
07959	OTH SPECFIED RETROVIRUS	86
07981	HANTAVIRUS INFECTION	97
07988	OTH SPCF CHLAMYDIAL INFC	97
07989	OTH SPECF VIRAL INFECTN	97
07998	CHLAMYDIAL INFECTION NOS	97
07999	VIRAL INFECTION NOS	97
080	LOUSE-BORNE TYPHUS	97
0810	MURINE TYPHUS	97

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
0811	BRILL'S DISEASE	97
0812	SCRUB TYPHUS	97
0819	TYPHUS NOS	97
0820	SPOTTED FEVERS	97
0821	BOUTONNEUSE FEVER	97
0822	NORTH ASIAN TICK FEVER	97
0823	QUEENSLAND TICK TYPHUS	97
0828	TICK-BORNE RICKETTS NEC	97
0829	TICK-BORNE RICKETTS NOS	97
0830	Q FEVER	97
0831	TRENCH FEVER	97
0832	RICKETTSIALPOX	97
0838	RICKETTSIOSES NEC	97
0839	RICKETTSIOSIS NOS	97
0840	FALCIPARUM MALARIA	97
0841	VIVAX MALARIA	97
0842	QUARTAN MALARIA	97
0843	OVALE MALARIA	97
0844	MALARIA NEC	97
0845	MIXED MALARIA	97
0846	MALARIA NOS	97
0847	INDUCED MALARIA	97
0848	BLACKWATER FEVER	97
0849	MALARIA COMPLICATED NEC	97
0850	VISCERAL LEISHMANIASIS	97
0851	CUTAN LEISHMANIAS URBAN	18
0852	CUTAN LEISHMANIAS ASIAN	18
0853	CUTAN LEISHMANIAS ETHIOP	18
0854	CUTAN LEISHMANIAS AMER	18
0855	MUCOCUTAN LEISHMANIASIS	18
0859	LEISHMANIASIS NOS	97
0860	CHAGAS DISEASE OF HEART	36
0861	CHAGAS DIS OF OTH ORGAN	97
0862	CHAGAS DISEASE NOS	97
0863	GAMBIAN TRYPANOSOMIASIS	97
0864	RHODESIAN TRYPANOSOMIAS	97
0865	AFRICAN TRYPANOSOMA NOS	97
0869	TRYPANOSOMIASIS NOS	97
0870	LOUSE-BORNE RELAPS FEVER	97
0871	TICK-BORNE RELAPS FEVER	97
0879	RELAPSING FEVER NOS	97
0880	BARTONELLOSIS	97
08881	LYME DISEASE	97
08882	BABESIOSIS	97
08889	OTH ARTHROPOD-BORNE DIS	97
0889	ARTHROPOD-BORNE DIS NOS	97
0900	EARLY CONG SYPH SYMPTOM	97
0901	EARLY CONGEN SYPH LATENT	97
0902	EARLY CONGEN SYPH NOS	97
0903	SYPHILITIC KERATITIS	68
09040	JUVENILE NEUROSYPH NOS	63
09041	CONGEN SYPH ENCEPHALITIS	63
09042	CONGEN SYPH MENINGITIS	63
09049	JUVENILE NEUROSYPH NEC	63
0905	LATE CONGEN SYPH SYMPTOM	97
0906	LATE CONGEN SYPH LATENT	97
0907	LATE CONGEN SYPH NOS	97
0909	CONGENITAL SYPHILIS NOS	97
0910	PRIMARY GENITAL SYPHILIS	97
0911	PRIMARY ANAL SYPHILIS	41
0912	PRIMARY SYPHILIS NEC	97
0913	SECONDARY SYPH SKIN	18
0914	SYPHILITIC ADENOPATHY	97
09150	SYPHILITIC UVEITIS NOS	68
09151	SYPHILIT CHORIORETINITIS	68
09152	SYPHILITIC IRIDOCYCLITIS	68
09161	SYPHILITIC PERIOSTITIS	24
09162	SYPHILITIC HEPATITIS	41
09169	SECOND SYPH VISCERA NEC	41
0917	SECOND SYPHILIS RELAPSE	97
09181	ACUTE SYPHIL MENINGITIS	63
09182	SYPHILITIC ALOPECIA	18
09189	SECONDARY SYPHILIS NEC	97
0919	SECONDARY SYPHILIS NOS	97
0920	EARLY SYPH LATENT RELAPS	97
0929	EARLY SYPHIL LATENT NOS	97

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
0930	AORTIC ANEURYSM, SYPHIL	36
0931	SYPHILITIC AORTITIS	36
09320	SYPHIL ENDOCARDITIS NOS	36
09321	SYPHILITIC MITRAL VALVE	36
09322	SYPHILITIC AORTIC VALVE	36
09323	SYPHIL TRICUSPID VALVE	36
09324	SYPHIL PULMONARY VALVE	36
09381	SYPHILITIC PERICARDITIS	36
09382	SYPHILITIC MYOCARDITIS	36
09389	CARDIOVASCULAR SYPH NEC	36
0939	CARDIOVASCULAR SYPH NOS	36
0940	TABES DORSALIS	63
0941	GENERAL PARESIS	63
0942	SYPHILITIC MENINGITIS	63
0943	ASYMPTOMAT NEUROSYPHILIS	63
09481	SYPHILITIC ENCEPHALITIS	63
09482	SYPHILITIC PARKINSONISM	63
09483	SYPH DISSEM RETINITIS	68
09484	SYPHILITIC OPTIC ATROPHY	68
09485	SYPH RETROBULB NEURITIS	63
09486	SYPHIL ACOUSTIC NEURITIS	31
09487	SYPH RUPT CEREB ANEURYSM	63
09489	NEUROSYPHILIS NEC	63
0949	NEUROSYPHILIS NOS	63
0950	SYPHILITIC EPISCLERITIS	68
0951	SYPHILIS OF LUNG	33
0952	SYPHILITIC PERITONITIS	41
0953	SYPHILIS OF LIVER	41
0954	SYPHILIS OF KIDNEY	53
0955	SYPHILIS OF BONE	24
0956	SYPHILIS OF MUSCLE	24
0957	SYPHILIS OF TENDON/BURSA	24
0958	LATE SYMPT SYPHILIS NEC	97
0959	LATE SYMPT SYPHILIS NOS	97
096	LATE SYPHILIS LATENT	97
0970	LATE SYPHILIS NOS	97
0971	LATENT SYPHILIS NOS	97
0979	SYPHILIS NOS	97
0980	ACUTE GC INFECT LOWER GU	97
09810	GC (ACUTE) UPPER GU NOS	97
09811	GC CYSTITIS (ACUTE)	53
09812	GC PROSTATITIS (ACUTE)	53
09813	GC ORCHITIS (ACUTE)	97
09814	GC SEM VESICULIT (ACUTE)	97
09815	GC CERVICITIS (ACUTE)	97
09816	GC ENDOMETRITIS (ACUTE)	97
09817	ACUTE GC SALPINGITIS	97
09819	GC (ACUTE) UPPER GU NEC	97
0982	CHR GC INFECT LOWER GU	97
09830	CHR GC UPPER GU NOS	53
09831	GC CYSTITIS, CHRONIC	53
09832	GC PROSTATITIS, CHRONIC	53
09833	GC ORCHITIS, CHRONIC	97
09834	GC SEM VESICULITIS, CHR	97
09835	GC CERVICITIS, CHRONIC	97
09836	GC ENDOMETRITIS, CHRONIC	97
09837	GC SALPINGITIS (CHRONIC)	97
09839	CHR GC UPPER GU NEC	97
09840	GONOCOCCAL CONJUNCTIVIT	68
09841	GONOCOCCAL IRIDOCYCLITIS	68
09842	GONOCOCCAL ENDOPHTHALMIA	68
09843	GONOCOCCAL KERATITIS	68
09849	GONOCOCCAL EYE NEC	68
09850	GONOCOCCAL ARTHRITIS	24
09851	GONOCOCCAL SYNOVITIS	24
09852	GONOCOCCAL BURSITIS	24
09853	GONOCOCCAL SPONDYLITIS	24
09859	GC INFECT JOINT NEC	24
0986	GONOCOCCAL INFEC PHARYNX	31
0987	GC INFECT ANUS & RECTUM	97
09881	GONOCOCCAL KERATOSIS	68
09882	GONOCOCCAL MENINGITIS	63
09883	GONOCOCCAL PERICARDITIS	36
09884	GONOCOCCAL ENDOCARDITIS	36
09885	GONOCOCCAL HEART DIS NEC	36
09886	GONOCOCCAL PERITONITIS	41

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
09889	GONOCOCCAL INF SITE NEC	97
0990	CHANCROID	97
0991	LYMPHOGRANULOMA VENEREUM	97
0992	GRANULOMA INGUINALE	97
0993	REITER'S DISEASE	24
09940	UNSPCF NONGNCCL URETHRTS	97
09941	CHLMYD TRACHOMATIS URETH	97
09949	NONGC URTH OTH SPF ORGSM	97
09950	OTH VD CHLM TRCH UNSP ST	97
09951	OTH VD CHLM TRCH PHARYNX	97
09952	OTH VD CHLM TRCH ANS RCT	97
09953	OTH VD CHLM TRCH LOWR GU	97
09954	OTH VD CHLM TRCH OTH GU	97
09955	OT VD CHLM TRCH UNSPF GU	97
09956	OT VD CHLM TRCH PRTONEUM	97
09959	OTH VD CHLM TRCH SPCF ST	97
0998	VENEREAL DISEASE NEC	97
0999	VENEREAL DISEASE NOS	97
1000	LEPTOSPIROS ICTEROHEM	97
10081	LEPTOSPIRAL MENINGITIS	63
10089	LEPTOSPIRAL INFECT NEC	63
1009	LEPTOSPIROSIS NOS	97
101	VINCENT'S ANGINA	31
1020	INITIAL LESIONS YAWS	18
1021	MULTIPLE PAPILLOMATA	18
1022	EARLY SKIN YAWS NEC	18
1023	HYPERKERATOSIS OF YAWS	18
1024	GUMMATA AND ULCERS, YAWS	18
1025	GANGOSA	31
1026	YAWS OF BONE & JOINT	24
1027	YAWS MANIFESTATIONS NEC	97
1028	LATENT YAWS	97
1029	YAWS NOS	97
1030	PINTA PRIMARY LESIONS	18
1031	PINTA INTERMED LESIONS	18
1032	PINTA LATE LESIONS	97
1033	PINTA MIXED LESIONS	18
1039	PINTA NOS	97
1040	NONVENEREAL ENDEMIC SYPH	97
1048	SPIROCHETAL INFECT NEC	97
1049	SPIROCHETAL INFECT NOS	97
1100	DERMATOPHYT SCALP/BEARD	18
1101	DERMATOPHYTOSIS OF NAIL	18
1102	DERMATOPHYTOSIS OF HAND	18
1103	DERMATOPHYTOSIS OF GROIN	18
1104	DERMATOPHYTOSIS OF FOOT	18
1105	DERMATOPHYTOSIS OF BODY	18
1106	DEEP DERMATOPHYTOSIS	18
1108	DERMATOPHYTOSIS SITE NEC	18
1109	DERMATOPHYTOSIS SITE NOS	18
1110	PITYRIASIS VERSICOLOR	18
1111	TINEA NIGRA	18
1112	TINEA BLANCA	18
1113	BLACK PIEDRA	18
1118	DERMATOMYCOSES NEC	18
1119	DERMATOMYCOSIS NOS	18
1120	THRUSH	31
1121	CANDIDAL VULVOVAGINITIS	97
1122	CANDIDIAS UROGENITAL NEC	97
1123	CUTANEOUS CANDIDIASIS	18
1124	CANDIDIASIS OF LUNG	33
1125	DISSEMINATED CANDIDIASIS	97
11281	CANDIDAL ENDOCARDITIS	36
11282	CANDIDAL OTITIS EXTERNA	31
11283	CANDIDAL MENINGITIS	63
11284	CANDIDAL ESOPHAGITIS	97
11285	CANDIDAL ENTERITIS	97
11289	CANDIDIASIS SITE NEC	97
1129	CANDIDIASIS SITE NOS	18
1140	PRIMARY COCCIDIOIDOMYCOS	33
1141	PRIM CUTAN COCCIDIOID	18
1142	COCCIDIOIDAL MENINGITIS	63
1143	PROGRESS COCCIDIOID NEC	97
1144	CH PL COCCIDIOIDOMYCOSIS	97
1145	PL COCIDIOIDOMYCOSIS NOS	97
1149	COCCIDIOIDOMYCOSIS NOS	97

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
11500	HISTOPLASMA CAPSULAT NOS	97
11501	HISTOPLASM CAPSUL MENING	63
11502	HISTOPLASM CAPSUL RETINA	68
11503	HISTOPLASM CAPS PERICARD	36
11504	HISTOPLASM CAPS ENDOCARD	36
11505	HISTOPLASM CAPS PNEUMON	33
11509	HISTOPLASMA CAPSULAT NEC	97
11510	HISTOPLASMA DUBOISII NOS	97
11511	HISTOPLASM DUBOIS MENING	63
11512	HISTOPLASM DUBOIS RETINA	68
11513	HISTOPLASM DUB PERICARD	36
11514	HISTOPLASM DUB ENDOCARD	36
11515	HISTOPLASM DUB PNEUMONIA	33
11519	HISTOPLASMA DUBOISII NEC	97
11590	HISTOPLASMOSIS NOS	97
11591	HISTOPLASMOSIS MENINGIT	63
11592	HISTOPLASMOSIS RETINITIS	68
11593	HISTOPLASMOSIS PERICARD	36
11594	HISTOPLASMOSIS ENDOCARD	36
11595	HISTOPLASMOSIS PNEUMONIA	33
11599	HISTOPLASMOSIS NEC	97
1160	BLASTOMYCOSIS	97
1161	PARACOCCIDIOIDOMYCOSIS	97
1162	LOBOMYCOSIS	97
1170	RHINOSPORIDIOSIS	97
1171	SPOROTRICHOSIS	97
1172	CHROMOBLASTOMYCOSIS	97
1173	ASPERGILLOSIS	97
1174	MYCOTIC MYCETOMAS	97
1175	CRYPTOCOCCOSIS	97
1176	ALLESCHERIOSIS	97
1177	ZYGOMYCOSIS	97
1178	DEMATIACIOUS FUNGI INF	97
1179	MYCOSES NEC & NOS	18
118	OPPORTUNISTIC MYCOSES	97
1200	SCHISTOSOMA HAEMATOBIUM	53
1201	SCHISTOSOMA MANSONI	41
1202	SCHISTOSOMA JAPONICUM	97
1203	CUTANEOUS SCHISTOSOMA	18
1208	SCHISTOSOMIASIS NEC	97
1209	SCHISTOSOMIASIS NOS	97
1210	OPISTHORCHIASIS	41
1211	CLONORCHIASIS	41
1212	PARAGONIMIASIS	33
1213	FASCIOLIASIS	41
1214	FASCIOLOPSIASIS	41
1215	METAGONIMIASIS	97
1216	HETEROPHYIASIS	97
1218	TREMATODE INFECTION NEC	97
1219	TREMATODE INFECTION NOS	97
1220	ECHINOCOCC GRANUL LIVER	41
1221	ECHINOCOCC GRANUL LUNG	33
1222	ECHINOCOCC GRAN THYROID	82
1223	ECHINOCOCC GRANUL NEC	97
1224	ECHINOCOCC GRANUL NOS	97
1225	ECHINOCOC MULTILOC LIVER	41
1226	ECHINOCOCC MULTILOC NEC	97
1227	ECHINOCOCC MULTILOC NOS	97
1228	ECHINOCOCCOSIS NOS LIVER	41
1229	ECHINOCOCCOSIS NEC/NOS	97
1230	TAENIA SOLIUM INTESTINE	41
1231	CYSTICERCOSIS	41
1232	TAENIA SAGINATA INFECT	41
1233	TAENIASIS NOS	41
1234	DIPHYLLOBOTHRIAS INTEST	41
1235	SPARGANOSIS	41
1236	HYMENOLEPIASIS	41
1238	CESTODE INFECTION NEC	41
1239	CESTODE INFECTION NOS	41
124	TRICHINOSIS	97
1250	BANCROFTIAN FILARIASIS	97
1251	MALAYAN FILARIASIS	97
1252	LOIASIS	97
1253	ONCHOCERCIASIS	97
1254	DIPETALONEMIASIS	97
1255	MANSONELLA OZZARDI INFEC	97

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
1256	FILARIASIS NEC	97
1257	DRACONTIASIS	97
1259	FILARIASIS NOS	97
1260	ANCYLOSTOMA DUODENALE	41
1261	NECATOR AMERICANUS	41
1262	ANCYLOSTOMA BRAZILIENSE	41
1263	ANCYLOSTOMA CEYLANICUM	41
1268	ANCYLOSTOMA NEC	41
1269	ANCYLOSTOMIASIS NOS	41
1270	ASCARIASIS	41
1271	ANISAKIASIS	41
1272	STRONGYLOIDIASIS	41
1273	TRICHURIASIS	41
1274	ENTEROBIASIS	41
1275	CAPILLARIASIS	41
1276	TRICHOSTRONGYLIASIS	41
1277	INTEST HELMINTHIASIS NEC	41
1278	MIXED INTESTINE HELMINTH	97
1279	INTEST HELMINTHIASIS NOS	41
1280	TOXOCARIASIS	97
1281	GNATHOSTOMIASIS	97
1288	HELMINTHIASIS NEC	97
1289	HELMINTHIASIS NOS	97
129	INTESTIN PARASITISM NOS	41
1300	TOXOPLASM MENINGOENCEPH	63
1301	TOXOPLASM CONJUNCTIVITIS	68
1302	TOXOPLASM CHORIORETINIT	68
1303	TOXOPLASMA MYOCARDITIS	36
1304	TOXOPLASMA PNEUMONITIS	33
1305	TOXOPLASMA HEPATITIS	41
1307	TOXOPLASMOSIS SITE NEC	97
1308	MULTISYSTEM TOXOPLASMOS	97
1309	TOXOPLASMOSIS NOS	97
13100	UROGENITAL TRICHOMON NOS	97
13101	TRICHOMONAL VAGINITIS	97
13102	TRICHOMONAL URETHRITIS	97
13103	TRICHOMONAL PROSTATITIS	97
13109	UROGENITAL TRICHOMON NEC	97
1318	TRICHOMONIASIS NEC	97
1319	TRICHOMONIASIS NOS	97
1320	PEDICULUS CAPITIS	18
1321	PEDICULUS CORPORIS	18
1322	PHTHIRUS PUBIS	18
1323	MIXED PEDICUL & PHTHIRUS	18
1329	PEDICULOSIS NOS	18
1330	SCABIES	18
1338	ACARIASIS NEC	18
1339	ACARIASIS NOS	18
1340	MYIASIS	18
1341	ARTHROPOD INFEST NEC	18
1342	HIRUDINIASIS	18
1348	INFESTATION NEC	18
1349	INFESTATION NOS	18
135	SARCOIDOSIS	33
1360	AINHUM	97
1361	BEHCET'S SYNDROME	24
1362	FREE-LIVING AMEBA INFECT	97
1363	PNEUMOCYSTOSIS	33
1364	PSOROSPERMIASIS	97
1365	SARCOSPORIDIOSIS	97
1368	INFECT/PARASITE DIS NEC	97
1369	INFECT/PARASITE DIS NOS	97
1370	LATE EFFECT TB, RESP/NOS	33
1371	LATE EFFECT CNS TB	63
1372	LATE EFFECT GU TB	53
1373	LATE EFF BONE & JOINT TB	24
1374	LATE EFFECT TB NEC	97
138	LATE EFFECT ACUTE POLIO	63
1390	LATE EFF VIRAL ENCEPHAL	63
1391	LATE EFFECT OF TRACHOMA	68
1398	LATE EFF INFECT DIS NEC	97
1400	MAL NEO UPPER VERMILION	88
1401	MAL NEO LOWER VERMILION	88
1403	MAL NEO UPPER LIP, INNER	88
1404	MAL NEO LOWER LIP, INNER	88
1405	MAL NEO LIP, INNER NOS	88

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
1406	MAL NEO LIP, COMMISSURE	88
1408	MAL NEO LIP NEC	88
1409	MAL NEO LIP/VERMIL NOS	88
1410	MAL NEO TONGUE BASE	88
1411	MAL NEO DORSAL TONGUE	88
1412	MAL NEO TIP/LAT TONGUE	88
1413	MAL NEO VENTRAL TONGUE	88
1414	MAL NEO ANT 2/3 TONGUE	88
1415	MAL NEO TONGUE JUNCTION	88
1416	MAL NEO LINGUAL TONSIL	88
1418	MALIG NEO TONGUE NEC	88
1419	MALIG NEO TONGUE NOS	88
1420	MALIG NEO PAROTID	88
1421	MALIG NEO SUBMANDIBULAR	88
1422	MALIG NEO SUBLINGUAL	88
1428	MAL NEO MAJ SALIVARY NEC	88
1429	MAL NEO SALIVARY NOS	88
1430	MALIG NEO UPPER GUM	88
1431	MALIG NEO LOWER GUM	88
1438	MALIG NEO GUM NEC	88
1439	MALIG NEO GUM NOS	88
1440	MAL NEO ANT FLOOR MOUTH	88
1441	MAL NEO LAT FLOOR MOUTH	88
1448	MAL NEO MOUTH FLOOR NEC	88
1449	MAL NEO MOUTH FLOOR NOS	88
1450	MAL NEO CHEEK MUCOSA	88
1451	MAL NEO MOUTH VESTIBULE	88
1452	MALIG NEO HARD PALATE	88
1453	MALIG NEO SOFT PALATE	88
1454	MALIGNANT NEOPLASM UVULA	88
1455	MALIGNANT NEO PALATE NOS	88
1456	MALIG NEO RETROMOLAR	88
1458	MALIG NEOPLASM MOUTH NEC	88
1459	MALIG NEOPLASM MOUTH NOS	88
1460	MALIGNANT NEOPL TONSIL	88
1461	MAL NEO TONSILLAR FOSSA	88
1462	MAL NEO TONSIL PILLARS	88
1463	MALIGN NEOPL VALLECULA	88
1464	MAL NEO ANT EPIGLOTTIS	88
1465	MAL NEO EPIGLOTTIS JUNCT	88
1466	MAL NEO LAT OROPHARYNX	88
1467	MAL NEO POST OROPHARYNX	88
1468	MAL NEO OROPHARYNX NEC	88
1469	MALIG NEO OROPHARYNX NOS	88
1470	MAL NEO SUPER NASOPHARYN	88
1471	MAL NEO POST NASOPHARYNX	88
1472	MAL NEO LAT NASOPHARYNX	88
1473	MAL NEO ANT NASOPHARYNX	88
1478	MAL NEO NASOPHARYNX NEC	88
1479	MAL NEO NASOPHARYNX NOS	88
1480	MAL NEO POSTCRICOID	88
1481	MAL NEO PYRIFORM SINUS	88
1482	MAL NEO ARYEPIGLOTT FOLD	88
1483	MAL NEO POST HYPOPHARYNX	88
1488	MAL NEO HYPOPHARYNX NEC	88
1489	MAL NEO HYPOPHARYNX NOS	88
1490	MAL NEO PHARYNX NOS	88
1491	MAL NEO WALDEYER'S RING	88
1498	MAL NEO ORAL/PHARYNX NEC	88
1499	MAL NEO OROPHRYN ILL-DEF	88
1500	MAL NEO CERVICAL ESOPHAG	88
1501	MAL NEO THORACIC ESOPHAG	88
1502	MAL NEO ABDOMIN ESOPHAG	88
1503	MAL NEO UPPER 3RD ESOPH	88
1504	MAL NEO MIDDLE 3RD ESOPH	88
1505	MAL NEO LOWER 3RD ESOPH	88
1508	MAL NEO ESOPHAGUS NEC	88
1509	MAL NEO ESOPHAGUS NOS	88
1510	MAL NEO STOMACH CARDIA	88
1511	MALIGNANT NEO PYLORUS	88
1512	MAL NEO PYLORIC ANTRUM	88
1513	MAL NEO STOMACH FUNDUS	88
1514	MAL NEO STOMACH BODY	88
1515	MAL NEO STOM LESSER CURV	88
1516	MAL NEO STOM GREAT CURV	88
1518	MALIG NEOPL STOMACH NEC	88

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
1519	MALIG NEOPL STOMACH NOS	88
1520	MALIGNANT NEOPL DUODENUM	88
1521	MALIGNANT NEOPL JEJUNUM	88
1522	MALIGNANT NEOPLASM ILEUM	88
1523	MAL NEO MECKEL'S DIVERT	88
1528	MAL NEO SMALL BOWEL NEC	88
1529	MAL NEO SMALL BOWEL NOS	88
1530	MAL NEO HEPATIC FLEXURE	88
1531	MAL NEO TRANSVERSE COLON	88
1532	MAL NEO DESCEND COLON	88
1533	MAL NEO SIGMOID COLON	88
1534	MALIGNANT NEOPLASM CECUM	88
1535	MALIGNANT NEO APPENDIX	88
1536	MALIG NEO ASCEND COLON	88
1537	MAL NEO SPLENIC FLEXURE	88
1538	MALIGNANT NEO COLON NEC	88
1539	MALIGNANT NEO COLON NOS	88
1540	MAL NEO RECTOSIGMOID JCT	88
1541	MALIGNANT NEOPL RECTUM	88
1542	MALIG NEOPL ANAL CANAL	88
1543	MALIGNANT NEO ANUS NOS	88
1548	MAL NEO RECTUM/ANUS NEC	88
1550	MAL NEO LIVER, PRIMARY	88
1551	MAL NEO INTRAHEPAT DUCTS	88
1552	MALIGNANT NEO LIVER NOS	88
1560	MALIG NEO GALLBLADDER	88
1561	MAL NEO EXTRAHEPAT DUCTS	88
1562	MAL NEO AMPULLA OF VATER	88
1568	MALIG NEO BILIARY NEC	88
1569	MALIG NEO BILIARY NOS	88
1570	MAL NEO PANCREAS HEAD	88
1571	MAL NEO PANCREAS BODY	88
1572	MAL NEO PANCREAS TAIL	88
1573	MAL NEO PANCREATIC DUCT	88
1574	MAL NEO ISLET LANGERHANS	88
1578	MALIG NEO PANCREAS NEC	88
1579	MALIG NEO PANCREAS NOS	88
1580	MAL NEO RETROPERITONEUM	88
1588	MAL NEO PERITONEUM NEC	88
1589	MAL NEO PERITONEUM NOS	88
1590	MALIG NEO INTESTINE NOS	88
1591	MALIGNANT NEO SPLEEN NEC	88
1598	MAL NEO GI/INTRA-ABD NEC	88
1599	MAL NEO GI TRACT ILL-DEF	88
1600	MAL NEO NASAL CAVITIES	88
1601	MALIG NEO MIDDLE EAR	88
1602	MAL NEO MAXILLARY SINUS	88
1603	MAL NEO ETHMOIDAL SINUS	88
1604	MALIG NEO FRONTAL SINUS	88
1605	MAL NEO SPHENOID SINUS	88
1608	MAL NEO ACCESS SINUS NEC	88
1609	MAL NEO ACCESS SINUS NOS	88
1610	MALIGNANT NEO GLOTTIS	88
1611	MALIG NEO SUPRAGLOTTIS	88
1612	MALIG NEO SUBGLOTTIS	88
1613	MAL NEO CARTILAGE LARYNX	88
1618	MALIGNANT NEO LARYNX NEC	88
1619	MALIGNANT NEO LARYNX NOS	88
1620	MALIGNANT NEO TRACHEA	88
1622	MALIG NEO MAIN BRONCHUS	88
1623	MAL NEO UPPER LOBE LUNG	88
1624	MAL NEO MIDDLE LOBE LUNG	88
1625	MAL NEO LOWER LOBE LUNG	88
1628	MAL NEO BRONCH/LUNG NEC	88
1629	MAL NEO BRONCH/LUNG NOS	88
1630	MAL NEO PARIETAL PLEURA	88
1631	MAL NEO VISCERAL PLEURA	88
1638	MALIG NEOPL PLEURA NEC	88
1639	MALIG NEOPL PLEURA NOS	88
1640	MALIGNANT NEOPL THYMUS	88
1641	MALIGNANT NEOPL HEART	88
1642	MAL NEO ANT MEDIASTINUM	88
1643	MAL NEO POST MEDIASTINUM	88
1648	MAL NEO MEDIASTINUM NEC	88
1649	MAL NEO MEDIASTINUM NOS	88
1650	MAL NEO UPPER RESP NOS	88

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
1658	MAL NEO THORAX/RESP NEC	88
1659	MAL NEO RESP SYSTEM NOS	88
1700	MAL NEO SKULL/FACE BONE	88
1701	MALIGNANT NEO MANDIBLE	88
1702	MALIG NEO VERTEBRAE	88
1703	MAL NEO RIBS/STERN/CLAV	88
1704	MAL NEO LONG BONES ARM	88
1705	MAL NEO BONES WRIST/HAND	88
1706	MAL NEO PELVIC GIRDLE	88
1707	MAL NEO LONG BONES LEG	88
1708	MAL NEO BONES ANKLE/FOOT	88
1709	MALIG NEOPL BONE NOS	88
1710	MAL NEO SOFT TISSUE HEAD	88
1712	MAL NEO SOFT TISSUE ARM	88
1713	MAL NEO SOFT TISSUE LEG	88
1714	MAL NEO SOFT TIS THORAX	88
1715	MAL NEO SOFT TIS ABDOMEN	88
1716	MAL NEO SOFT TIS PELVIS	88
1717	MAL NEOPL TRUNK NOS	88
1718	MAL NEO SOFT TISSUE NEC	88
1719	MAL NEO SOFT TISSUE NOS	88
1720	MALIG MELANOMA LIP	88
1721	MALIG MELANOMA EYELID	88
1722	MALIG MELANOMA EAR	88
1723	MAL MELANOM FACE NEC/NOS	88
1724	MAL MELANOMA SCALP/NECK	88
1725	MALIG MELANOMA TRUNK	88
1726	MALIG MELANOMA ARM	88
1727	MALIG MELANOMA LEG	88
1728	MALIG MELANOMA SKIN NEC	88
1729	MALIG MELANOMA SKIN NOS	88
1730	MALIG NEO SKIN LIP	88
1731	MALIG NEO SKIN EYELID	88
1732	MALIG NEO SKIN EAR	88
1733	MAL NEO SKIN FACE NEC	88
1734	MAL NEO SCALP/SKIN NECK	88
1735	MALIG NEO SKIN TRUNK	88
1736	MALIG NEO SKIN ARM	88
1737	MALIG NEO SKIN LEG	88
1738	MALIG NEO SKIN NEC	88
1739	MALIG NEO SKIN NOS	88
1740	MALIG NEO NIPPLE	88
1741	MAL NEO BREAST-CENTRAL	88
1742	MAL NEO BREAST UP-INNER	88
1743	MAL NEO BREAST LOW-INNER	88
1744	MAL NEO BREAST UP-OUTER	88
1745	MAL NEO BREAST LOW-OUTER	88
1746	MAL NEO BREAST-AXILLARY	88
1748	MALIGN NEOPL BREAST NEC	88
1749	MALIGN NEOPL BREAST NOS	88
1750	MAL NEO MALE NIPPLE	88
1759	MAL NEO MALE BREAST NEC	88
1760	SKIN - KAPOSI'S SARCOMA	86
1761	SFT TISUE - KPSI'S SRCMA	86
1762	PALATE - KPSI's SARCOMA	86
1763	GI SITES - KPSI'S SRCOMA	86
1764	LUNG - KAPOSI'S SARCOMA	86
1765	LYM NDS - KPSI'S SARCOMA	86
1768	SPF STS - KPSI'S SARCOMA	86
1769	KAPOSI'S SARCOMA NOS	86
179	MALIG NEOPL UTERUS NOS	88
1800	MALIG NEO ENDOCERVIX	88
1801	MALIG NEO EXOCERVIX	88
1808	MALIG NEO CERVIX NEC	88
1809	MAL NEO CERVIX UTERI NOS	88
181	MALIGNANT NEOPL PLACENTA	88
1820	MALIG NEO CORPUS UTERI	88
1821	MAL NEO UTERINE ISTHMUS	88
1828	MAL NEO BODY UTERUS NEC	88
1830	MALIGN NEOPL OVARY	88
1832	MAL NEO FALLOPIAN TUBE	88
1833	MAL NEO BROAD LIGAMENT	88
1834	MALIG NEO PARAMETRIUM	88
1835	MAL NEO ROUND LIGAMENT	88
1838	MAL NEO ADNEXA NEC	88
1839	MAL NEO ADNEXA NOS	88

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
1840	MALIGN NEOPL VAGINA	88
1841	MAL NEO LABIA MAJORA	88
1842	MAL NEO LABIA MINORA	88
1843	MALIGN NEOPL CLITORIS	88
1844	MALIGN NEOPL VULVA NOS	88
1848	MAL NEO FEMALE GENIT NEC	88
1849	MAL NEO FEMALE GENIT NOS	88
185	MALIGN NEOPL PROSTATE	88
1860	MAL NEO UNDESCEND TESTIS	88
1869	MALIG NEO TESTIS NEC	88
1871	MALIGN NEOPL PREPUCE	88
1872	MALIG NEO GLANS PENIS	88
1873	MALIG NEO PENIS BODY	88
1874	MALIG NEO PENIS NOS	88
1875	MALIG NEO EPIDIDYMIS	88
1876	MAL NEO SPERMATIC CORD	88
1877	MALIGN NEOPL SCROTUM	88
1878	MAL NEO MALE GENITAL NEC	88
1879	MAL NEO MALE GENITAL NOS	88
1880	MAL NEO BLADDER-TRIGONE	88
1881	MAL NEO BLADDER-DOME	88
1882	MAL NEO BLADDER-LATERAL	88
1883	MAL NEO BLADDER-ANTERIOR	88
1884	MAL NEO BLADDER-POST	88
1885	MAL NEO BLADDER NECK	88
1886	MAL NEO URETERIC ORIFICE	88
1887	MALIG NEO URACHUS	88
1888	MALIG NEO BLADDER NEC	88
1889	MALIG NEO BLADDER NOS	88
1890	MALIG NEOPL KIDNEY	88
1891	MALIG NEO RENAL PELVIS	88
1892	MALIGN NEOPL URETER	88
1893	MALIGN NEOPL URETHRA	88
1894	MAL NEO PARAURETHRAL	88
1898	MAL NEO URINARY NEC	88
1899	MAL NEO URINARY NOS	88
1900	MALIGN NEOPL EYEBALL	88
1901	MALIGN NEOPL ORBIT	88
1902	MAL NEO LACRIMAL GLAND	88
1903	MAL NEO CONJUNCTIVA	88
1904	MALIGN NEOPL CORNEA	88
1905	MALIGN NEOPL RETINA	88
1906	MALIGN NEOPL CHOROID	88
1907	MAL NEO LACRIMAL DUCT	88
1908	MALIGN NEOPL EYE NEC	88
1909	MALIGN NEOPL EYE NOS	88
1910	MALIGN NEOPL CEREBRUM	88
1911	MALIG NEO FRONTAL LOBE	88
1912	MAL NEO TEMPORAL LOBE	88
1913	MAL NEO PARIETAL LOBE	88
1914	MAL NEO OCCIPITAL LOBE	88
1915	MAL NEO CEREB VENTRICLE	88
1916	MAL NEO CEREBELLUM NOS	88
1917	MAL NEO BRAIN STEM	88
1918	MALIG NEO BRAIN NEC	88
1919	MALIG NEO BRAIN NOS	88
1920	MAL NEO CRANIAL NERVES	88
1921	MAL NEO CEREBRAL MENING	88
1922	MAL NEO SPINAL CORD	88
1923	MAL NEO SPINAL MENINGES	88
1928	MAL NEO NERVOUS SYST NEC	88
1929	MAL NEO NERVOUS SYST NOS	88
193	MALIGN NEOPL THYROID	88
1940	MALIGN NEOPL ADRENAL	88
1941	MALIG NEO PARATHYROID	88
1943	MALIG NEO PITUITARY	88
1944	MALIGN NEO PINEAL GLAND	88
1945	MAL NEO CAROTID BODY	88
1946	MAL NEO PARAGANGLIA NEC	88
1948	MAL NEO ENDOCRINE NEC	88
1949	MAL NEO ENDOCRINE NOS	88
1950	MAL NEO HEAD/FACE/NECK	88
1951	MALIGN NEOPL THORAX	88
1952	MALIG NEO ABDOMEN	88
1953	MALIGN NEOPL PELVIS	88
1954	MALIGN NEOPL ARM	88

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
1955	MALIGN NEOPL LEG	88
1958	MALIG NEO SITE NEC	88
1960	MAL NEO LYMPH-HEAD/NECK	88
1961	MAL NEO LYMPH-INTRATHOR	88
1962	MAL NEO LYMPH INTRA-ABD	88
1963	MAL NEO LYMPH-AXILLA/ARM	88
1965	MAL NEO LYMPH-INGUIN/LEG	88
1966	MAL NEO LYMPH-INTRAPELV	88
1968	MAL NEO LYMPH NODE-MULT	88
1969	MAL NEO LYMPH NODE NOS	88
1970	SECONDARY MALIG NEO LUNG	88
1971	SEC MAL NEO MEDIASTINUM	88
1972	SECOND MALIG NEO PLEURA	88
1973	SEC MALIG NEO RESP NEC	88
1974	SEC MALIG NEO SM BOWEL	88
1975	SEC MALIG NEO LG BOWEL	88
1976	SEC MAL NEO PERITONEUM	88
1977	SECOND MALIG NEO LIVER	88
1978	SEC MAL NEO GI NEC	88
1980	SECOND MALIG NEO KIDNEY	88
1981	SEC MALIG NEO URIN NEC	88
1982	SECONDARY MALIG NEO SKIN	88
1983	SEC MAL NEO BRAIN/SPINE	88
1984	SEC MALIG NEO NERVE NEC	88
1985	SECONDARY MALIG NEO BONE	88
1986	SECOND MALIG NEO OVARY	88
1987	SECOND MALIG NEO ADRENAL	88
19881	SECOND MALIG NEO BREAST	88
19882	SECOND MALIG NEO GENITAL	88
19889	SECONDARY MALIG NEO NEC	88
1990	MALIG NEO DISSEMINATED	88
1991	MALIGNANT NEOPLASM NOS	88
20000	RETCLSRC UNSP XTRNDL ORG	88
20001	RETICULOSARCOMA HEAD	88
20002	RETICULOSARCOMA THORAX	88
20003	RETICULOSARCOMA ABDOM	88
20004	RETICULOSARCOMA AXILLA	88
20005	RETICULOSARCOMA INGUIN	88
20006	RETICULOSARCOMA PELVIC	88
20007	RETICULOSARCOMA SPLEEN	88
20008	RETICULOSARCOMA MULT	88
20010	LYMPHSRC UNSP XTRNDL ORG	88
20011	LYMPHOSARCOMA HEAD	88
20012	LYMPHOSARCOMA THORAX	88
20013	LYMPHOSARCOMA ABDOM	88
20014	LYMPHOSARCOMA AXILLA	88
20015	LYMPHOSARCOMA INGUIN	88
20016	LYMPHOSARCOMA PELVIC	88
20017	LYMPHOSARCOMA SPLEEN	88
20018	LYMPHOSARCOMA MULT	88
20020	BRKT TMR UNSP XTRNDL ORG	88
20021	BURKITT'S TUMOR HEAD	88
20022	BURKITT'S TUMOR THORAX	88
20023	BURKITT'S TUMOR ABDOM	88
20024	BURKITT'S TUMOR AXILLA	88
20025	BURKITT'S TUMOR INGUIN	88
20026	BURKITT'S TUMOR PELVIC	88
20027	BURKITT'S TUMOR SPLEEN	88
20028	BURKITT'S TUMOR MULT	88
20080	OTH VARN UNSP XTRNDL ORG	88
20081	MIXED LYMPHOSARC HEAD	88
20082	MIXED LYMPHOSARC THORAX	88
20083	MIXED LYMPHOSARC ABDOM	88
20084	MIXED LYMPHOSARC AXILLA	88
20085	MIXED LYMPHOSARC INGUIN	88
20086	MIXED LYMPHOSARC PELVIC	88
20087	MIXED LYMPHOSARC SPLEEN	88
20088	MIXED LYMPHOSARC MULT	88
20100	HDGK PRG UNSP XTRNDL ORG	88
20101	HODGKINS PARAGRAN HEAD	88
20102	HODGKINS PARAGRAN THORAX	88
20103	HODGKINS PARAGRAN ABDOM	88
20104	HODGKINS PARAGRAN AXILLA	88
20105	HODGKINS PARAGRAN INGUIN	88
20106	HODGKINS PARAGRAN PELVIC	88
20107	HODGKINS PARAGRAN SPLEEN	88

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
20108	HODGKINS PARAGRAN MULT	88
20110	HDGK GRN UNSP XTRNDL ORG	88
20111	HODGKINS GRANULOM HEAD	88
20112	HODGKINS GRANULOM THORAX	88
20113	HODGKINS GRANULOM ABDOM	88
20114	HODGKINS GRANULOM AXILLA	88
20115	HODGKINS GRANULOM INGUIN	88
20116	HODGKINS GRANULOM PELVIC	88
20117	HODGKINS GRANULOM SPLEEN	88
20118	HODGKINS GRANULOM MULT	88
20120	HDGK SRC UNSP XTRNDL ORG	88
20121	HODGKINS SARCOMA HEAD	88
20122	HODGKINS SARCOMA THORAX	88
20123	HODGKINS SARCOMA ABDOM	88
20124	HODGKINS SARCOMA AXILLA	88
20125	HODGKINS SARCOMA INGUIN	88
20126	HODGKINS SARCOMA PELVIC	88
20127	HODGKINS SARCOMA SPLEEN	88
20128	HODGKINS SARCOMA MULT	88
20140	LYM-HST UNSP XTRNDL ORGN	88
20141	HODG LYMPH-HISTIO HEAD	88
20142	HODG LYMPH-HISTIO THORAX	88
20143	HODG LYMPH-HISTIO ABDOM	88
20144	HODG LYMPH-HISTIO AXILLA	88
20145	HODG LYMPH-HISTIO INGUIN	88
20146	HODG LYMPH-HISTIO PELVIC	88
20147	HODG LYMPH-HISTIO SPLEEN	88
20148	HODG LYMPH-HISTIO MULT	88
20150	NDR SCLR UNSP XTRNDL ORG	88
20151	HODG NODUL SCLERO HEAD	88
20152	HODG NODUL SCLERO THORAX	88
20153	HODG NODUL SCLERO ABDOM	88
20154	HODG NODUL SCLERO AXILLA	88
20155	HODG NODUL SCLERO INGUIN	88
20156	HODG NODUL SCLERO PELVIC	88
20157	HODG NODUL SCLERO SPLEEN	88
20158	HODG NODUL SCLERO MULT	88
20160	MXD CELR UNSP XTRNDL ORG	88
20161	HODGKINS MIX CELL HEAD	88
20162	HODGKINS MIX CELL THORAX	88
20163	HODGKINS MIX CELL ABDOM	88
20164	HODGKINS MIX CELL AXILLA	88
20165	HODGKINS MIX CELL INGUIN	88
20166	HODGKINS MIX CELL PELVIC	88
20167	HODGKINS MIX CELL SPLEEN	88
20168	HODGKINS MIX CELL MULT	88
20170	LYM DPLT UNSP XTRNDL ORG	88
20171	HODG LYMPH DEPLET HEAD	88
20172	HODG LYMPH DEPLET THORAX	88
20173	HODG LYMPH DEPLET ABDOM	88
20174	HODG LYMPH DEPLET AXILLA	88
20175	HODG LYMPH DEPLET INGUIN	88
20176	HODG LYMPH DEPLET PELVIC	88
20177	HODG LYMPH DEPLET SPLEEN	88
20178	HODG LYMPH DEPLET MULT	88
20190	HDGK DIS UNSP XTRNDL ORG	88
20191	HODGKINS DIS NOS HEAD	88
20192	HODGKINS DIS NOS THORAX	88
20193	HODGKINS DIS NOS ABDOM	88
20194	HODGKINS DIS NOS AXILLA	88
20195	HODGKINS DIS NOS INGUIN	88
20196	HODGKINS DIS NOS PELVIC	88
20197	HODGKINS DIS NOS SPLEEN	88
20198	HODGKINS DIS NOS MULT	88
20200	NDLR LYM UNSP XTRNDL ORG	88
20201	NODULAR LYMPHOMA HEAD	88
20202	NODULAR LYMPHOMA THORAX	88
20203	NODULAR LYMPHOMA ABDOM	88
20204	NODULAR LYMPHOMA AXILLA	88
20205	NODULAR LYMPHOMA INGUIN	88
20206	NODULAR LYMPHOMA PELVIC	88
20207	NODULAR LYMPHOMA SPLEEN	88
20208	NODULAR LYMPHOMA MULT	88
20210	MYCS FNG UNSP XTRNDL ORG	88
20211	MYCOSIS FUNGOIDES HEAD	88
20212	MYCOSIS FUNGOIDES THORAX	88

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
20213	MYCOSIS FUNGOIDES ABDOM	88
20214	MYCOSIS FUNGOIDES AXILLA	88
20215	MYCOSIS FUNGOIDES INGUIN	88
20216	MYCOSIS FUNGOIDES PELVIC	88
20217	MYCOSIS FUNGOIDES SPLEEN	88
20218	MYCOSIS FUNGOIDES MULT	88
20220	SZRY DIS UNSP XTRNDL ORG	88
20221	SEZARY'S DISEASE HEAD	88
20222	SEZARY'S DISEASE THORAX	88
20223	SEZARY'S DISEASE ABDOM	88
20224	SEZARY'S DISEASE AXILLA	88
20225	SEZARY'S DISEASE INGUIN	88
20226	SEZARY'S DISEASE PELVIC	88
20227	SEZARY'S DISEASE SPLEEN	88
20228	SEZARY'S DISEASE MULT	88
20230	MLG HIST UNSP XTRNDL ORG	88
20231	MAL HISTIOCYTOSIS HEAD	88
20232	MAL HISTIOCYTOSIS THORAX	88
20233	MAL HISTIOCYTOSIS ABDOM	88
20234	MAL HISTIOCYTOSIS AXILLA	88
20235	MAL HISTIOCYTOSIS INGUIN	88
20236	MAL HISTIOCYTOSIS PELVIC	88
20237	MAL HISTIOCYTOSIS SPLEEN	88
20238	MAL HISTIOCYTOSIS MULT	88
20240	LK RTCTL UNSP XTRNDL ORG	88
20241	HAIRY-CELL LEUKEM HEAD	88
20242	HAIRY-CELL LEUKEM THORAX	88
20243	HAIRY-CELL LEUKEM ABDOM	88
20244	HAIRY-CELL LEUKEM AXILLA	88
20245	HAIRY-CELL LEUKEM INGUIN	88
20246	HAIRY-CELL LEUKEM PELVIC	88
20247	HAIRY-CELL LEUKEM SPLEEN	88
20248	HAIRY-CELL LEUKEM MULT	88
20250	LTR-SIWE UNSP XTRNDL ORG	88
20251	LETTERER-SIWE DIS HEAD	88
20252	LETTERER-SIWE DIS THORAX	88
20253	LETTERER-SIWE DIS ABDOM	88
20254	LETTERER-SIWE DIS AXILLA	88
20255	LETTERER-SIWE DIS INGUIN	88
20256	LETTERER-SIWE DIS PELVIC	88
20257	LETTERER-SIWE DIS SPLEEN	88
20258	LETTERER-SIWE DIS MULT	88
20260	MLG MAST UNSP XTRNDL ORG	88
20261	MAL MASTOCYTOSIS HEAD	88
20262	MAL MASTOCYTOSIS THORAX	88
20263	MAL MASTOCYTOSIS ABDOM	88
20264	MAL MASTOCYTOSIS AXILLA	88
20265	MAL MASTOCYTOSIS INGUIN	88
20266	MAL MASTOCYTOSIS PELVIC	88
20267	MAL MASTOCYTOSIS SPLEEN	88
20268	MAL MASTOCYTOSIS MULT	88
20280	OTH LYMP UNSP XTRNDL ORG	88
20281	LYMPHOMAS NEC HEAD	88
20282	LYMPHOMAS NEC THORAX	88
20283	LYMPHOMAS NEC ABDOM	88
20284	LYMPHOMAS NEC AXILLA	88
20285	LYMPHOMAS NEC INGUIN	88
20286	LYMPHOMAS NEC PELVIC	88
20287	LYMPHOMAS NEC SPLEEN	88
20288	LYMPHOMAS NEC MULT	88
20290	UNSP LYM UNSP XTRNDL ORG	88
20291	LYMPHOID MAL NEC HEAD	88
20292	LYMPHOID MAL NEC THORAX	88
20293	LYMPHOID MAL NEC ABDOM	88
20294	LYMPHOID MAL NEC AXILLA	88
20295	LYMPHOID MAL NEC INGUIN	88
20296	LYMPHOID MAL NEC PELVIC	88
20297	LYMPHOID MAL NEC SPLEEN	88
20298	LYMPHOID MAL NEC MULT	88
20300	MULT MYELM W/O REMISSION	88
20301	MULT MYELM W REMISSION	88
20310	PLSM CELL LEUK W/O RMSON	88
20311	PLSM CELL LEUK W RMSON	88
20380	OTH IMNPRFL NPL W/O RMSN	88
20381	OTH IMNPRFL NPL W RMSN	88
20400	ACT LYM LEUK W/O RMSION	88

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
20401	ACT LYM LEUK W RMSION	88
20410	CHR LYM LEUK W/O RMSION	88
20411	CHR LYM LEUK W RMSION	88
20420	SBAC LYM LEUK W/O RMSION	88
20421	SBAC LYM LEUK W RMSION	88
20480	OTH LYM LEUK W/O RMSION	88
20481	OTH LYM LEUK W RMSION	88
20490	UNS LYM LEUK W/O RMSION	88
20491	UNS LYM LEUK W RMSION	88
20500	ACT MYL LEUK W/O RMSION	88
20501	ACT MYL LEUK W RMSION	88
20510	CHR MYL LEUK W/O RMSION	88
20511	CHR MYL LEUK W RMSION	88
20520	SBAC MYL LEUK W/O RMSION	88
20521	SBAC MYL LEUK W RMSION	88
20530	MYL SRCOMA W/O RMSION	88
20531	MYL SRCOMA W RMSION	88
20580	OTH MYL LEUK W/O RMSION	88
20581	OTH MYL LEUK W RMSION	88
20590	UNS MYL LEUK W/O RMSION	88
20591	UNS MYL LEUK W RMSION	88
20600	ACT MONO LEUK W/O RMSION	88
20601	ACT MONO LEUK W RMSION	88
20610	CHR MONO LEUK W/O RMSION	88
20611	CHR MONO LEUK W RMSION	88
20620	SBAC MONO LEUK W/O RMSON	88
20621	SBAC MONO LEUK W RMSION	88
20680	OTH MONO LEUK W/O RMSION	88
20681	OTH MONO LEUK W RMSION	88
20690	UNS MONO LEUK W/O RMSION	88
20691	UNS MONO LEUK W RMSION	88
20700	ACT ERTH/ERYLK W/O RMSON	88
20701	ACT ERTH/ERYLK W RMSON	88
2071	CHRONIC ERYTHREMIA*	88
20710	CHR ERYTHRM W/O REMISION	88
20711	CHR ERYTHRM W REMISION	88
2072	MEGAKARYOCYTIC LEUKEMIA*	88
20720	MGKRYCYT LEUK W/O RMSION	88
20721	MGKRYCYT LEUK W RMSION	88
2078	SPECIFIED LEUKEMIA NEC*	88
20780	OTH SPF LEUK W/O REMSION	88
20781	OTH SPF LEUK W REMSION	88
2080	ACT LEUK UNS CL W/O RMSN*	88
20800	ACT LEUK UNS CL W/O RMSN	88
20801	ACT LEUK UNS CL W RMSON	88
2081	CHRONIC LEUKEMIA NOS*	88
20810	CHR LEUK UNS CL W/O RMSN	88
20811	CHR LEUK UNS CL W RMSON	88
2082	SUBACUTE LEUKEMIA NOS*	88
20820	SBAC LEUK UNS CL W/O RMS	88
20821	SBAC LEUK UNS CL W RMSON	88
2088	LEUKEMIA-UNSPEC CELL NEC*	88
20880	OTH LEUK UNS CL W/O RMSN	88
20881	OTH LEUK UNS CL W RMSON	88
2089	LEUKEMIA-UNSPEC CELL NOS*	88
20890	LEUKEMIA NOS W/O REMSION	88
20891	LEUKEMIA NOS W REMISSION	88
2100	BENIGN NEOPLASM LIP	31
2101	BENIGN NEOPLASM TONGUE	31
2102	BEN NEO MAJOR SALIVARY	31
2103	BENIGN NEO MOUTH FLOOR	31
2104	BENIGN NEO MOUTH NEC/NOS	31
2105	BENIGN NEOPLASM TONSIL	31
2106	BENIGN NEO OROPHARYN NEC	31
2107	BENIGN NEO NASOPHARYNX	31
2108	BENIGN NEO HYPOPHARYNX	31
2109	BENIGN NEO PHARYNX NOS	31
2110	BENIGN NEO ESOPHAGUS	41
2111	BENIGN NEOPLASM STOMACH	41
2112	BENIGN NEOPLASM SM BOWEL	41
2113	BENIGN NEOPLASM LG BOWEL	41
2114	BENIGN NEOPL RECTUM/ANUS	41
2115	BEN NEO LIVER/BILE DUCTS	41
2116	BENIGN NEOPLASM PANCREAS	41
2117	BEN NEO ISLETS LANGERHAN	82
2118	BEN NEO PERITONEUM	41

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
2119	BEN NEO GI TRACT NEC/NOS	41
2120	BEN NEO NASAL CAV/SINUS	31
2121	BENIGN NEO LARYNX	31
2122	BENIGN NEO TRACHEA	33
2123	BENIGN NEO BRONCHUS/LUNG	33
2124	BENIGN NEOPLASM PLEURA	33
2125	BENIGN NEO MEDIASTINUM	33
2126	BENIGN NEOPLASM THYMUS	86
2127	BENIGN NEOPLASM HEART	36
2128	BENIGN NEO RESP SYS NEC	33
2129	BENIGN NEO RESP SYS NOS	33
2130	BEN NEO SKULL/FACE BONE	24
2131	BEN NEO LOWER JAW BONE	31
2132	BENIGN NEO VERTEBRAE	24
2133	BEN NEO RIBS/STERN/CLAV	33
2134	BEN NEO LONG BONES ARM	24
2135	BEN NEO BONES WRIST/HAND	24
2136	BENIGN NEO PELVIC GIRDLE	24
2137	BEN NEO LONG BONES LEG	24
2138	BEN NEO BONES ANKLE/FOOT	24
2139	BENIGN NEO BONE NOS	24
2140	LIPOMA SKIN FACE	18
2141	LIPOMA SKIN NEC	18
2142	LIPOMA INTRATHORACIC	33
2143	LIPOMA INTRA-ABDOMINAL	41
2144	LIPOMA SPERMATIC CORD	53
2148	LIPOMA NEC	18
2149	LIPOMA NOS	18
2150	BEN NEO SOFT TISSUE HEAD	18
2152	BEN NEO SOFT TISSUE ARM	18
2153	BEN NEO SOFT TISSUE LEG	18
2154	BEN NEO SOFT TIS THORAX	18
2155	BEN NEO SOFT TIS ABDOMEN	18
2156	BEN NEO SOFT TIS PELVIS	18
2157	BENIGN NEO TRUNK NOS	18
2158	BEN NEO SOFT TISSUE NEC	18
2159	BEN NEO SOFT TISSUE NOS	18
2160	BENIGN NEO SKIN LIP	18
2161	BENIGN NEO SKIN EYELID	68
2162	BENIGN NEO SKIN EAR	18
2163	BENIGN NEO SKIN FACE NEC	18
2164	BEN NEO SCALP/SKIN NECK	18
2165	BENIGN NEO SKIN TRUNK	18
2166	BENIGN NEO SKIN ARM	18
2167	BENIGN NEO SKIN LEG	18
2168	BENIGN NEOPLASM SKIN NEC	18
2169	BENIGN NEOPLASM SKIN NOS	18
217	BENIGN NEOPLASM BREAST	18
2180	SUBMUCOUS LEIOMYOMA	56
2181	INTRAMURAL LEIOMYOMA	56
2182	SUBSEROUS LEIOMYOMA	56
2189	UTERINE LEIOMYOMA NOS	56
2190	BENIGN NEO CERVIX UTERI	56
2191	BENIGN NEO CORPUS UTERI	56
2198	BENIGN NEO UTERUS NEC	56
2199	BENIGN NEO UTERUS NOS	56
220	BENIGN NEOPLASM OVARY	56
2210	BEN NEO FALLOPIAN TUBE	56
2211	BENIGN NEOPLASM VAGINA	56
2212	BENIGN NEOPLASM VULVA	56
2218	BEN NEO FEM GENITAL NEC	56
2219	BEN NEO FEM GENITAL NOS	56
2220	BENIGN NEOPLASM TESTIS	53
2221	BENIGN NEOPLASM PENIS	53
2222	BENIGN NEOPLASM PROSTATE	53
2223	BENIGN NEO EPIDIDYMIS	53
2224	BENIGN NEOPLASM SCROTUM	53
2228	BEN NEO MALE GENITAL NEC	53
2229	BEN NEO MALE GENITAL NOS	53
2230	BENIGN NEOPLASM KIDNEY	53
2231	BENIGN NEO RENAL PELVIS	53
2232	BENIGN NEOPLASM URETER	53
2233	BENIGN NEOPLASM BLADDER	53
22381	BENIGN NEOPLASM URETHRA	53
22389	BENIGN NEO URINARY NEC	53
2239	BENIGN NEO URINARY NOS	53

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
2240	BENIGN NEOPLASM EYEBALL	68
2241	BENIGN NEOPLASM ORBIT	68
2242	BEN NEO LACRIMAL GLAND	68
2243	BENIGN NEO CONJUNCTIVA	68
2244	BENIGN NEOPLASM CORNEA	68
2245	BENIGN NEOPLASM RETINA	68
2246	BENIGN NEOPLASM CHOROID	68
2247	BEN NEO LACRIMAL DUCT	68
2248	BENIGN NEOPLASM EYE NEC	68
2249	BENIGN NEOPLASM EYE NOS	68
2250	BENIGN NEOPLASM BRAIN	63
2251	BENIGN NEO CRANIAL NERVE	63
2252	BEN NEO CEREBR MENINGES	63
2253	BENIGN NEO SPINAL CORD	63
2254	BEN NEO SPINAL MENINGES	63
2258	BENIGN NEO NERV SYS NEC	63
2259	BENIGN NEO NERV SYS NOS	63
226	BENIGN NEOPLASM THYROID	82
2270	BENIGN NEOPLASM ADRENAL	82
2271	BENIGN NEO PARATHYROID	82
2273	BENIGN NEO PITUITARY	82
2274	BEN NEOPL PINEAL GLAND	63
2275	BENIGN NEO CAROTID BODY	63
2276	BEN NEO PARAGANGLIA NEC	63
2278	BENIGN NEO ENDOCRINE NEC	82
2279	BENIGN NEO ENDOCRINE NOS	82
22800	HEMANGIOMA NOS	36
22801	HEMANGIOMA SKIN	18
22802	HEMANGIOMA INTRACRANIAL	63
22803	HEMANGIOMA RETINA	68
22804	HEMANGIOMA INTRA-ABDOM	41
22809	HEMANGIOMA NEC	36
2281	LYMPHANGIOMA, ANY SITE	86
2290	BENIGN NEO LYMPH NODES	86
2298	BENIGN NEOPLASM NEC	18
2299	BENIGN NEOPLASM NOS	18
2300	CA IN SITU ORAL CAV/PHAR	88
2301	CA IN SITU ESOPHAGUS	88
2302	CA IN SITU STOMACH	88
2303	CA IN SITU COLON	88
2304	CA IN SITU RECTUM	88
2305	CA IN SITU ANAL CANAL	88
2306	CA IN SITU ANUS NOS	88
2307	CA IN SITU BOWEL NEC/NOS	88
2308	CA IN SITU LIVER/BILIARY	88
2309	CA IN SITU GI NEC/NOS	88
2310	CA IN SITU LARYNX	88
2311	CA IN SITU TRACHEA	88
2312	CA IN SITU BRONCHUS/LUNG	88
2318	CA IN SITU RESP SYS NEC	88
2319	CA IN SITU RESP SYS NOS	88
2320	CA IN SITU SKIN LIP	88
2321	CA IN SITU EYELID	88
2322	CA IN SITU SKIN EAR	88
2323	CA IN SITU SKIN FACE NEC	88
2324	CA IN SITU SCALP	88
2325	CA IN SITU SKIN TRUNK	88
2326	CA IN SITU SKIN ARM	88
2327	CA IN SITU SKIN LEG	88
2328	CA IN SITU SKIN NEC	88
2329	CA IN SITU SKIN NOS	88
2330	CA IN SITU BREAST	88
2331	CA IN SITU CERVIX UTERI	88
2332	CA IN SITU UTERUS NEC	88
2333	CA IN SITU FEM GEN NEC	88
2334	CA IN SITU PROSTATE	88
2335	CA IN SITU PENIS	88
2336	CA IN SITU MALE GEN NEC	88
2337	CA IN SITU BLADDER	88
2339	CA IN SITU URINARY NEC	88
2340	CA IN SITU EYE	88
2348	CA IN SITU NEC	88
2349	CA IN SITU NOS	88
2350	UNC BEHAV NEO SALIVARY	88
2351	UNC BEHAV NEO ORAL/PHAR	88
2352	UNC BEHAV NEO INTESTINE	88

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
2353	UNC BEHAV NEO LIVER	88
2354	UNC BEHAV NEO PERITONEUM	88
2355	UNC BEHAV NEO GI NEC	88
2356	UNC BEHAV NEO LARYNX	88
2357	UNC BEHAV NEO LUNG	88
2358	UNC BEHAV NEO PLEURA	88
2359	UNC BEHAV NEO RESP NEC	88
2360	UNCERT BEHAV NEO UTERUS	88
2361	UNC BEHAV NEO PLACENTA	88
2362	UNC BEHAV NEO OVARY	88
2363	UNC BEHAV NEO FEMALE NEC	88
2364	UNC BEHAV NEO TESTIS	88
2365	UNC BEHAV NEO PROSTATE	88
2366	UNC BEHAV NEO MALE NEC	88
2367	UNC BEHAV NEO BLADDER	88
23690	UNC BEHAV NEO URINAR NOS	88
23691	UNC BEHAV NEO KIDNEY	88
23699	UNC BEHAV NEO URINAR NEC	88
2370	UNC BEHAV NEO PITUITARY	88
2371	UNC BEHAV NEO PINEAL	88
2372	UNC BEHAV NEO ADRENAL	88
2373	UNC BEHAV NEO PARAGANG	88
2374	UNCER NEO ENDOCRINE NEC	88
2375	UNC BEH NEO BRAIN/SPINAL	88
2376	UNC BEHAV NEO MENINGES	88
2377	NEUROFIBROMATOSIS*	88
23770	NEUROFIBROMATOSIS NOS	63
23771	NEUROFIBROMATOSIS TYPE I	63
23772	NEUROFIBROMATOSIS TYP II	63
2379	UNC BEH NEO NERV SYS NEC	88
2380	UNC BEHAV NEO BONE	88
2381	UNC BEHAV NEO SOFT TISSU	88
2382	UNC BEHAV NEO SKIN	88
2383	UNC BEHAV NEO BREAST	88
2384	POLYCYTHEMIA VERA	88
2385	MASTOCYTOMA NOS	88
2386	PLASMACYTOMA NOS	88
2387	LYMPHOPROLIFERAT DIS NOS	88
2388	UNCERT BEHAVIOR NEO NEC	88
2389	UNCERT BEHAVIOR NEO NOS	88
2390	DIGESTIVE NEOPLASM NOS	88
2391	RESPIRATORY NEOPLASM NOS	88
2392	BONE/SKIN NEOPLASM NOS	88
2393	BREAST NEOPLASM NOS	88
2394	BLADDER NEOPLASM NOS	88
2395	OTHER GU NEOPLASM NOS	88
2396	BRAIN NEOPLASM NOS	88
2397	ENDOCRINE/NERV NEO NOS	88
2398	NEOPLASM NOS, SITE NEC	88
2399	NEOPLASM NOS	88
2400	SIMPLE GOITER	82
2409	GOITER NOS	82
2410	NONTOX UNINODULAR GOITER	82
2411	NONTOX MULTINODUL GOITER	82
2419	NONTOX NODUL GOITER NOS	82
24200	TOX DIF GOITER NO CRISIS	82
24201	TOX DIF GOITER W CRISIS	78
24210	TOX UNINOD GOIT NO CRIS	82
24211	TOX UNINOD GOIT W CRISIS	78
24220	TOX MULTNOD GOIT NO CRIS	82
24221	TOX MULTNOD GOIT W CRIS	78
24230	TOX NOD GOITER NO CRISIS	82
24231	TOX NOD GOITER W CRISIS	78
24240	THYROTOX-ECT NOD NO CRIS	82
24241	THYROTOX-ECT NOD W CRIS	78
24280	THYRTOX ORIG NEC NO CRIS	82
24281	THYROTOX ORIG NEC W CRIS	78
24290	THYROTOX NOS NO CRISIS	82
24291	THYROTOX NOS W CRISIS	78
243	CONGENITAL HYPOTHYROIDSM	82
2440	POSTSURGICAL HYPOTHYROID	82
2441	POSTABLAT HYPOTHYR NEC	82
2442	IODINE HYPOTHYROIDISM	82
2443	IATROGEN HYPOTHYROID NEC	82
2448	ACQUIRED HYPOTHYROID NEC	82
2449	HYPOTHYROIDISM NOS	82

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
2450	ACUTE THYROIDITIS	82
2451	SUBACUTE THYROIDITIS	82
2452	CHR LYMPHOCYT THYROIDIT	82
2453	CHR FIBROUS THYROIDITIS	82
2454	IATROGENIC THYROIDITIS	82
2458	CHR THYROIDITIS NEC/NOS	82
2459	THYROIDITIS NOS	82
2460	DIS THYROCALCITON SECRET	82
2461	DYSHORMONOGENIC GOITER	82
2462	CYST OF THYROID	82
2463	HEMORR/INFARC THYROID	82
2468	DISORDERS OF THYROID NEC	82
2469	DISORDER OF THYROID NOS	82
25000	DMII WO CMP NT ST UNCNTR	82
25001	DMI WO CMP NT ST UNCNTRL	82
25002	DMII WO CMP UNCNTRLD	82
25003	DMI WO CMP UNCNTRLD	82
25010	DMII KETO NT ST UNCNTRLD	78
25011	DMI KETO NT ST UNCNTRLD	78
25012	DMII KETOACD UNCONTROLD	78
25013	DMI KETOACD UNCONTROLD	78
25020	DMII HPRSM NT ST UNCNTRL	78
25021	DMI HPRSM NT ST UNCNTRLD	78
25022	DMII HPROSMLR UNCONTROLD	78
25023	DMI HPROSMLR UNCONTROLD	78
25030	DMII O CM NT ST UNCNTRLD	78
25031	DMI O CM NT ST UNCNTRLD	78
25032	DMII OTH COMA UNCONTROLD	78
25033	DMI OTH COMA UNCONTROLD	78
25040	DMII RENL NT ST UNCNTRLD	53
25041	DMI RENL NT ST UNCNTRLD	53
25042	DMII RENAL UNCNTRLD	82
25043	DMI RENAL UNCNTRLD	82
25050	DMII OPHTH NT ST UNCNTRL	68
25051	DMI OPHTH NT ST UNCNTRLD	68
25052	DMII OPHTH UNCNTRLD	82
25053	DMI OPHTH UNCNTRLD	82
25060	DMII NEURO NT ST UNCNTRL	63
25061	DMI NEURO NT ST UNCNTRLD	63
25062	DMII NEURO UNCNTRLD	82
25063	DMI NEURO UNCNTRLD	82
25070	DMII CIRC NT ST UNCNTRLD	82
25071	DMI CIRC NT ST UNCNTRLD	82
25072	DMII CIRC UNCNTRLD	82
25073	DMI CIRC UNCNTRLD	82
25080	DMII OTH NT ST UNCNTRLD	82
25081	DMI OTH NT ST UNCNTRLD	82
25082	DMII OTH UNCNTRLD	82
25083	DMI OTH UNCNTRLD	82
25090	DMII UNSPF NT ST UNCNTRL	82
25091	DMI UNSPF NT ST UNCNTRLD	82
25092	DMII UNSPF UNCNTRLD	82
25093	DMI UNSPF UNCNTRLD	82
2510	HYPOGLYCEMIC COMA	78
2511	OTH SPCF HYPOGLYCEMIA	82
2512	HYPOGLYCEMIA NOS	82
2513	POSTSURG HYPOINSULINEMIA	82
2514	ABN SECRETION GLUCAGON	82
2515	ABNORM SECRETION GASTRIN	41
2518	PANCREATIC DISORDER NEC	82
2519	PANCREATIC DISORDER NOS	82
2520	HYPERPARATHYROIDISM	82
2521	HYPOPARATHYROIDISM	82
2528	PARATHYROID DISORDER NEC	82
2529	PARATHYROID DISORDER NOS	82
2530	ACROMEGALY AND GIGANTISM	82
2531	ANT PITUIT HYPERFUNC NEC	82
2532	PANHYPOPITUITARISM	82
2533	PITUITARY DWARFISM	82
2534	ANTER PITUITARY DIS NEC	82
2535	DIABETES INSIPIDUS	82
2536	NEUROHYPOPHYSIS DIS NEC	82
2537	IATROGENIC PITUITARY DIS	82
2538	PITUITARY DISORDER NEC	82
2539	PITUITARY DISORDER NOS	82
2540	PERSIST HYPERPLAS THYMUS	86

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
2541	ABSCESS OF THYMUS	86
2548	DISEASES OF THYMUS NEC	86
2549	DISEASE OF THYMUS NOS	86
2550	CUSHING'S SYNDROME	82
2551	HYPERALDOSTERONISM	82
2552	ADRENOGENITAL DISORDERS	82
2553	CORTICOADREN OVERACT NEC	82
2554	CORTICOADRENAL INSUFFIC	82
2555	ADRENAL HYPOFUNCTION NEC	82
2556	MEDULLOADRENAL HYPERFUNC	82
2558	ADRENAL DISORDER NEC	82
2559	ADRENAL DISORDER NOS	82
2560	HYPERESTROGENISM	56
2561	OVARIAN HYPERFUNC NEC	56
2562	POSTABLATIV OVARIAN FAIL	56
2563	OVARIAN FAILURE NEC	56
2564	POLYCYSTIC OVARIES	56
2568	OVARIAN DYSFUNCTION NEC	56
2569	OVARIAN DYSFUNCTION NOS	56
2570	TESTICULAR HYPERFUNCTION	82
2571	POSTABLAT TESTIC HYPOFUN	82
2572	TESTICULAR HYPOFUNC NEC	82
2578	TESTICULAR DYSFUNCT NEC	82
2579	TESTICULAR DYSFUNCT NOS	82
2580	WERMER'S SYNDROME	82
2581	COMB ENDOCR DYSFUNCT NEC	82
2588	POLYGLANDUL DYSFUNC NEC	82
2589	POLYGLANDUL DYSFUNC NOS	82
2590	DELAY SEXUAL DEVELOP NEC	82
2591	SEXUAL PRECOCITY NEC	82
2592	CARCINOID SYNDROME	82
2593	ECTOPIC HORMONE SECR NEC	82
2594	DWARFISM NEC	82
2598	ENDOCRINE DISORDERS NEC	82
2599	ENDOCRINE DISORDER NOS	82
260	KWASHIORKOR	82
261	NUTRITIONAL MARASMUS	82
262	OTH SEVERE MALNUTRITION	82
2630	MALNUTRITION MOD DEGREE	82
2631	MALNUTRITION MILD DEGREE	82
2632	ARREST DEVEL D/T MALNUTR	82
2638	PROTEIN-CAL MALNUTR NEC	82
2639	PROTEIN-CAL MALNUTR NOS	82
2640	VIT A CONJUNCTIV XEROSIS	68
2641	VIT A BITOT'S SPOT	68
2642	VIT A CORNEAL XEROSIS	68
2643	VIT A CORNEA ULCER/XEROS	68
2644	VIT A KERATOMALACIA	68
2645	VIT A NIGHT BLINDNESS	68
2646	VIT A DEF W CORNEAL SCAR	68
2647	VIT A OCULAR DEFIC NEC	68
2648	VITAMIN A DEFICIENCY NEC	82
2649	VITAMIN A DEFICIENCY NOS	82
2650	BERIBERI	82
2651	THIAMINE DEFIC NEC/NOS	82
2652	PELLAGRA	82
2660	ARIBOFLAVINOSIS	82
2661	VITAMIN B6 DEFICIENCY	82
2662	B-COMPLEX DEFIC NEC	82
2669	VITAMIN B DEFICIENCY NOS	82
267	ASCORBIC ACID DEFICIENCY	82
2680	RICKETS, ACTIVE	24
2681	RICKETS, LATE EFFECT	24
2682	OSTEOMALACIA NOS	24
2689	VITAMIN D DEFICIENCY NOS	82
2690	DEFICIENCY OF VITAMIN K	82
2691	VITAMIN DEFICIENCY NEC	82
2692	VITAMIN DEFICIENCY NOS	82
2693	MINERAL DEFICIENCY NEC	82
2698	NUTRITION DEFICIENCY NEC	82
2699	NUTRITION DEFICIENCY NOS	82
2700	AMINO-ACID TRANSPORT DIS	82
2701	PHENYLKETONURIA-PKU	82
2702	AROM AMIN-ACID METAB NEC	82
2703	BRAN-CHAIN AMIN-ACID DIS	82
2704	SULPH AMINO-ACID MET DIS	82

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
2705	DIS HISTIDINE METABOLISM	82
2706	DIS UREA CYCLE METABOL	82
2707	STRAIG AMIN-ACID MET NEC	82
2708	DIS AMINO-ACID METAB NEC	82
2709	DIS AMINO-ACID METAB NOS	82
2710	GLYCOGENOSIS	82
2711	GALACTOSEMIA	82
2712	HERED FRUCTOSE INTOLERAN	41
2713	DISACCHARIDASE DEF/MALAB	41
2714	RENAL GLYCOSURIA	82
2718	DIS CARBOHYDR METAB NEC	82
2719	DIS CARBOHYDR METAB NOS	82
2720	PURE HYPERCHOLESTEROLEM	82
2721	PURE HYPERGLYCERIDEMIA	82
2722	MIXED HYPERLIPIDEMIA	82
2723	HYPERCHYLOMICRONEMIA	82
2724	HYPERLIPIDEMIA NEC/NOS	82
2725	LIPOPROTEIN DEFICIENCIES	82
2726	LIPODYSTROPHY	82
2727	LIPIDOSES	82
2728	LIPOID METABOL DIS NEC	82
2729	LIPOID METABOL DIS NOS	82
2730	POLYCLON HYPERGAMMAGLOBU	86
2731	MONOCLON PARAPROTEINEMIA	86
2732	PARAPROTEINEMIA NEC	88
2733	MACROGLOBULINEMIA	88
2738	DIS PLAS PROTEIN MET NEC	88
2739	DIS PLAS PROTEIN MET NOS	88
2740	GOUTY ARTHROPATHY	24
27410	GOUTY NEPHROPATHY NOS	53
27411	URIC ACID NEPHROLITHIAS	53
27419	GOUTY NEPHROPATHY NEC	53
27481	GOUTY TOPHI OF EAR	24
27482	GOUTY TOPHI SITE NEC	24
27489	GOUT W MANIFESTATION NEC	24
2749	GOUT NOS	24
2750	DIS IRON METABOLISM	82
2751	DIS COPPER METABOLISM	82
2752	DIS MAGNESIUM METABOLISM	82
2753	DIS PHOSPHORUS METABOL	82
2754	DIS CALCIUM METABOLISM*	82
2758	DIS MINERAL METABOL NEC	82
2759	DIS MINERAL METABOL NOS	82
2760	HYPEROSMOLALITY	82
2761	HYPOSMOLALITY	82
2762	ACIDOSIS	82
2763	ALKALOSIS	82
2764	MIXED ACID-BASE BAL DIS	82
2765	HYPOVOLEMIA	82
2766	FLUID OVERLOAD	82
2767	HYPERPOTASSEMIA	82
2768	HYPOPOTASSEMIA	82
2769	ELECTROLYT/FLUID DIS NEC	82
27700	CYSTIC FIBROS W/O ILEUS	82
27701	CYSTIC FIBROSIS W ILEUS	57
2771	DIS PORPHYRIN METABOLISM	82
2772	PURINE/PYRIMID DIS NEC	82
2773	AMYLOIDOSIS	86
2774	DIS BILIRUBIN EXCRETION	41
2775	MUCOPOLYSACCHARIDOSIS	82
2776	DEFIC CIRCUL ENZYME NEC	82
2778	METABOLISM DISORDER NEC	82
2779	METABOLISM DISORDER NOS	82
2780	OBESITY*	82
27800	OBESITY NOS	82
27801	MORBID OBESITY	82
2781	LOCALIZED ADIPOSITY	82
2782	HYPERVITAMINOSIS A	82
2783	HYPERCAROTINEMIA	82
2784	HYPERVITAMINOSIS D	82
2788	OTHER HYPERALIMENTATION	82
27900	HYPOGAMMAGLOBULINEM NOS	86
27901	SELECTIVE IGA IMMUNODEF	86
27902	SELECTIVE IGM IMMUNODEF	86
27903	SELECTIVE IG DEFIC NEC	86
27904	CONG HYPOGAMMAGLOBULINEM	86

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
27905	IMMUNODEFIC W HYPER-IGM	86
27906	COMMON VARIABL IMMUNODEF	86
27909	HUMORAL IMMUNITY DEF NEC	86
27910	IMMUNDEF T-CELL DEF NOS	86
27911	DIGEORGE'S SYNDROME	86
27912	WISKOTT-ALDRICH SYNDROME	86
27913	NEZELOF'S SYNDROME	86
27919	DEFIC CELL IMMUNITY NOS	86
2792	COMBINED IMMUNITY DEFIC	86
2793	IMMUNITY DEFICIENCY NOS	86
2794	AUTOIMMUNE DISEASE NEC	24
2798	IMMUNE MECHANISM DIS NEC	86
2799	IMMUNE MECHANISM DIS NOS	86
2800	CHR BLOOD LOSS ANEMIA	86
2801	IRON DEF ANEMIA DIETARY	86
2808	IRON DEFIC ANEMIA NEC	86
2809	IRON DEFIC ANEMIA NOS	86
2810	PERNICIOUS ANEMIA	86
2811	B12 DEFIC ANEMIA NEC	86
2812	FOLATE-DEFICIENCY ANEMIA	86
2813	MEGALOBLASTIC ANEMIA NEC	86
2814	PROTEIN DEFIC ANEMIA	86
2818	NUTRITIONAL ANEMIA NEC	86
2819	DEFICIENCY ANEMIA NOS	86
2820	HEREDITARY SPHEROCYTOSIS	86
2821	HEREDIT ELLIPTOCYTOSIS	86
2822	GLUTATHIONE DIS ANEMIA	86
2823	ENZYME DEFIC ANEMIA NEC	86
2824	THALASSEMIAS	86
2825	SICKLE-CELL TRAIT	86
28260	SICKLE-CELL ANEMIA NOS	86
28261	HB-S DISEASE W/O CRISIS	86
28262	HB-S DISEASE WITH CRISIS	86
28263	SICKLE-CELL/HB-C DISEASE	86
28269	SICKLE-CELL ANEMIA NEC	86
2827	HEMOGLOBINOPATHIES NEC	86
2828	HERED HEMOLYTIC ANEM NEC	86
2829	HERED HEMOLYTIC ANEM NOS	86
2830	AUTOIMMUN HEMOLYTIC ANEM	86
2831	NONAUTOIMMU HEMOLYT ANEM*	86
28310	NONAUTO HEM ANEMIA NOS	86
28311	HEMOLYTIC UREMIC SYND	86
28319	OTH NONAUTO HEM ANEMIA	86
2832	HEMOLYTIC HEMOGLOBINURIA	86
2839	ACQ HEMOLYTIC ANEMIA NOS	86
2840	CONGEN APLASTIC ANEMIA	86
2848	APLASTIC ANEMIAS NEC	86
2849	APLASTIC ANEMIA NOS	86
2850	SIDEROBLASTIC ANEMIA	86
2851	AC POSTHEMORRHAG ANEMIA	86
2858	ANEMIA NEC	86
2859	ANEMIA NOS	86
2860	CONG FACTOR VIII DIORD	86
2861	CONG FACTOR IX DISORDER	86
2862	CONG FACTOR XI DISORDER	86
2863	CONG DEF CLOT FACTOR NEC	86
2864	VON WILLEBRAND'S DISEASE	86
2865	CIRCULATING ANTICOAG DIS	86
2866	DEFIBRINATION SYNDROME	86
2867	ACQ COAGUL FACTOR DEFIC	86
2869	COAGULAT DEFECT NEC/NOS	86
2870	ALLERGIC PURPURA	86
2871	THROMBOCYTOPATHY	86
2872	PURPURA NOS	86
2873	PRIMARY THROMBOCYTOPENIA	86
2874	SECOND THROMBOCYTOPENIA	86
2875	THROMBOCYTOPENIA NOS	86
2878	HEMORRHAGIC COND NEC	86
2879	HEMORRHAGIC COND NOS	86
2880	AGRANULOCYTOSIS	86
2881	FUNCTION DIS NEUTROPHILS	86
2882	GENETIC ANOMALY LEUKOCYT	86
2883	EOSINOPHILIA	86
2888	WBC DISEASE NEC	86
2889	WBC DISEASE NOS	86
2890	SECONDARY POLYCYTHEMIA	86

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
2891	CHRONIC LYMPHADENITIS	86
2892	MESENTERIC LYMPHADENITIS	41
2893	LYMPHADENITIS NOS	86
2894	HYPERSPLENISM	86
28950	SPLEEN DISEASE NOS	86
28951	CHR CONGEST SPLENOMEGALY	86
28959	SPLEEN DISEASE NEC	86
2896	FAMILIAL POLYCYTHEMIA	86
2897	METHEMOGLOBINEMIA	86
2898	BLOOD DISEASES NEC	86
2899	BLOOD DISEASE NOS	86
*2900	SENILE DEMENTIA UNCOMP	.....
29010	PRESENILE DEMENTIA	91
29011	PRESENILE DELIRIUM	91
29012	PRESENILE DELUSION	91
29013	PRESENILE DEPRESSION	91
29020	SENILE DELUSION	91
29021	SENILE DEPRESSIVE	91
2903	SENILE DELIRIUM	91
29040	ARTERIOSCLER DEMENT NOS	91
29041	ARTERIOSCLER DELIRIUM	91
29042	ARTERIOSCLER DELUSION	91
29043	ARTERIOSCLER DEPRESSIVE	91
2908	SENILE PSYCHOSIS NEC	91
2909	SENILE PSYCHOT COND NOS	91
2910	DELIRIUM TREMENS	91
2911	ALCOHOL AMNESTIC SYND	91
2912	ALCOHOLIC DEMENTIA NEC	91
2913	ALCOHOL HALLUCINOSIS	91
2914	PATHOLOGIC ALCOHOL INTOX	91
2915	ALCOHOLIC JEALOUSY	91
2918	ALCOHOLIC PSYCHOSIS NEC*	91
2919	ALCOHOLIC PSYCHOSIS NOS	91
2920	DRUG WITHDRAWAL SYNDROME	91
29211	DRUG PARANOID STATE	91
29212	DRUG HALLUCINOSIS	91
2922	PATHOLOGIC DRUG INTOX	91
29281	DRUG-INDUCED DELIRIUM	91
29282	DRUG-INDUCED DEMENTIA	91
29283	DRUG AMNESTIC SYNDROME	91
29284	DRUG DEPRESSIVE SYNDROME	91
29289	DRUG MENTAL DISORDER NEC	91
2929	DRUG MENTAL DISORDER NOS	91
2930	ACUTE DELIRIUM	91
2931	SUBACUTE DELIRIUM	91
29381	ORGANIC DELUSIONAL SYND	91
29382	ORGANIC HALLUCINOSIS SYN	91
29383	ORGANIC AFFECTIVE SYND	91
29389	TRANSIENT ORG MENTAL NEC	91
2939	TRANSIENT ORG MENTAL NOS	91
2940	AMNESTIC SYNDROME	91
2941	DEMENTIA IN OTH DISEASES	91
2948	ORGANIC BRAIN SYND NEC	91
2949	ORGANIC BRAIN SYND NOS	91
29500	SIMPL SCHIZOPHREN-UNSPEC	91
29501	SIMPL SCHIZOPHREN-SUBCHR	91
29502	SIMPLE SCHIZOPHREN-CHR	91
29503	SIMP SCHIZ-SUBCHR/EXACER	91
29504	SIMPL SCHIZO-CHR/EXACERB	91
29505	SIMPL SCHIZOPHREN-REMISS	91
29510	HEBEPHRENIA-UNSPEC	91
29511	HEBEPHRENIA-SUBCHRONIC	91
29512	HEBEPHRENIA-CHRONIC	91
29513	HEBEPHREN-SUBCHR/EXACERB	91
29514	HEBEPHRENIA-CHR/EXACERB	91
29515	HEBEPHRENIA-REMISSION	91
29520	CATATONIA-UNSPEC	91
29521	CATATONIA-SUBCHRONIC	91
29522	CATATONIA-CHRONIC	91
29523	CATATONIA-SUBCHR/EXACERB	91
29524	CATATONIA-CHR/EXACERB	91
29525	CATATONIA-REMISSION	91
29530	PARANOID SCHIZO-UNSPEC	91
29531	PARANOID SCHIZO-SUBCHR	91
29532	PARANOID SCHIZO-CHRONIC	91
29533	PARAN SCHIZO-SUBCHR/EXAC	91

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
29534	PARAN SCHIZO-CHR/EXACERB	91
29535	PARANOID SCHIZO-REMISS	91
29540	AC SCHIZOPHRENIA-UNSPEC	91
29541	AC SCHIZOPHRENIA-SUBCHR	91
29542	AC SCHIZOPHRENIA-CHR	91
29543	AC SCHIZO-SUBCHR/EXACERB	91
29544	AC SCHIZOPHR-CHR/EXACERB	91
29545	AC SCHIZOPHRENIA-REMISS	91
29550	LATENT SCHIZOPHREN-UNSP	91
29551	LAT SCHIZOPHREN-SUBCHR	91
29552	LATENT SCHIZOPHREN-CHR	91
29553	LAT SCHIZO-SUBCHR/EXACER	91
29554	LATENT SCHIZO-CHR/EXACER	91
29555	LAT SCHIZOPHREN-REMISS	91
29560	RESID SCHIZOPHREN-UNSP	91
29561	RESID SCHIZOPHREN-SUBCHR	91
29562	RESIDUAL SCHIZOPHREN-CHR	91
29563	RESID SCHIZO-SUBCHR/EXAC	91
29564	RESID SCHIZO-CHR/EXACERB	91
29565	RESID SCHIZOPHREN-REMISS	91
29570	SCHIZOAFFECTIVE-UNSPEC	91
29571	SCHIZOAFFECTIVE-SUBCHR	91
29572	SCHIZOAFFECTIVE-CHRONIC	91
29573	SCHIZOAFF-SUBCHR/EXACER	91
29574	SCHIZOAFFECT-CHR/EXACER	91
29575	SCHIZOAFFECTIVE-REMISS	91
29580	SCHIZOPHRENIA NEC-UNSPEC	91
29581	SCHIZOPHRENIA NEC-SUBCHR	91
29582	SCHIZOPHRENIA NEC-CHR	91
29583	SCHIZO NEC-SUBCHR/EXACER	91
29584	SCHIZO NEC-CHR/EXACERB	91
29585	SCHIZOPHRENIA NEC-REMISS	91
29590	SCHIZOPHRENIA NOS-UNSPEC	91
29591	SCHIZOPHRENIA NOS-SUBCHR	91
29592	SCHIZOPHRENIA NOS-CHR	91
29593	SCHIZO NOS-SUBCHR/EXACER	91
29594	SCHIZO NOS-CHR/EXACERB	91
29595	SCHIZOPHRENIA NOS-REMISS	91
29600	MANIC DISORDER-UNSPEC	91
29601	MANIC DISORDER-MILD	91
29602	MANIC DISORDER-MOD	91
29603	MANIC DISORDER-SEVERE	91
29604	MANIC DIS-SEVERE W PSYCH	91
29605	MANIC DIS-PARTIAL REMISS	91
29606	MANIC DIS-FULL REMISSION	91
29610	RECUR MANIC DIS-UNSPEC	91
29611	RECUR MANIC DIS-MILD	91
29612	RECUR MANIC DIS-MOD	91
29613	RECUR MANIC DIS-SEVERE	91
29614	RECUR MANIC-SEV W PSYCHO	91
29615	RECUR MANIC-PART REMISS	91
29616	RECUR MANIC-FULL REMISS	91
29620	DEPRESS PSYCHOSIS-UNSPEC	91
29621	DEPRESS PSYCHOSIS-MILD	91
29622	DEPRESSIVE PSYCHOSIS-MOD	91
29623	DEPRESS PSYCHOSIS-SEVERE	91
29624	DEPR PSYCHOS-SEV W PSYCH	91
29625	DEPR PSYCHOS-PART REMISS	91
29626	DEPR PSYCHOS-FULL REMISS	91
29630	RECURR DEPR PSYCHOS-UNSP	91
29631	RECURR DEPR PSYCHOS-MILD	91
29632	RECURR DEPR PSYCHOS-MOD	91
29633	RECUR DEPR PSYCH-SEVERE	91
29634	REC DEPR PSYCH-PSYCHOTIC	91
29635	RECUR DEPR PSYC-PART REM	91
29636	RECUR DEPR PSYC-FULL REM	91
29640	BIPOL AFF, MANIC-UNSPEC	91
29641	BIPOLAR AFF, MANIC-MILD	91
29642	BIPOLAR AFFEC, MANIC-MOD	91
29643	BIPOL AFF, MANIC-SEVERE	91
29644	BIPOL MANIC-SEV W PSYCH	91
29645	BIPOL AFF MANIC-PART REM	91
29646	BIPOL AFF MANIC-FULL REM	91
29650	BIPOLAR AFF, DEPR-UNSPEC	91
29651	BIPOLAR AFFEC, DEPR-MILD	91
29652	BIPOLAR AFFEC, DEPR-MOD	91

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
29653	BIPOL AFF, DEPR-SEVERE	91
29654	BIPOL DEPR-SEV W PSYCH	91
29655	BIPOL AFF DEPR-PART REM	91
29656	BIPOL AFF DEPR-FULL REM	91
29660	BIPOL AFF, MIXED-UNSPEC	91
29661	BIPOLAR AFF, MIXED-MILD	91
29662	BIPOLAR AFFEC, MIXED-MOD	91
29663	BIPOL AFF, MIXED-SEVERE	91
29664	BIPOL MIXED-SEV W PSYCH	91
29665	BIPOL AFF, MIX-PART REM	91
29666	BIPOL AFF, MIX-FULL REM	91
2967	BIPOLAR AFFECTIVE NOS	91
29680	MANIC-DEPRESSIVE NOS	91
29681	ATYPICAL MANIC DISORDER	91
29682	ATYPICAL DEPRESSIVE DIS	91
29689	MANIC-DEPRESSIVE NEC	91
29690	AFFECTIVE PSYCHOSIS NOS	91
29699	AFFECTIVE PSYCHOSES NEC	91
2970	PARANOID STATE, SIMPLE	91
2971	PARANOIA	91
2972	PARAPHRENIA	91
2973	SHARED PARANOID DISORDER	91
2978	PARANOID STATES NEC	91
2979	PARANOID STATE NOS	91
2980	REACT DEPRESS PSYCHOSIS	91
2981	EXCITATIV TYPE PSYCHOSIS	91
2982	REACTIVE CONFUSION	91
2983	ACUTE PARANOID REACTION	91
2984	PSYCHOGEN PARANOID PSYCH	91
2988	REACT PSYCHOSIS NEC/NOS	91
2989	PSYCHOSIS NOS	91
29900	INFANTILE AUTISM-ACTIVE	91
29901	INFANTILE AUTISM-RESID	91
29910	DISINTEGR PSYCH-ACTIVE	91
29911	DISINTEGR PSYCH-RESIDUAL	91
29980	CHILD PSYCHOS NEC-ACTIVE	91
29981	CHILD PSYCHOS NEC-RESID	91
29990	CHILD PSYCHOS NOS-ACTIVE	91
29991	CHILD PSYCHOS NOS-RESID	91
30000	ANXIETY STATE NOS	91
30001	PANIC DISORDER	91
30002	GENERALIZED ANXIETY DIS	91
30009	ANXIETY STATE NEC	91
30010	HYSTERIA NOS	91
30011	CONVERSION DISORDER	91
30012	PSYCHOGENIC AMNESIA	91
30013	PSYCHOGENIC FUGUE	91
30014	MULTIPLE PERSONALITY	91
30015	DISSOCIATIVE REACT NOS	91
30016	FACTITIOUS ILL W SYMPTOM	91
30019	FACTITIOUS ILL NEC/NOS	91
30020	PHOBIA NOS	91
30021	AGORAPHOBIA WITH PANIC	91
30022	AGORAPHOBIA W/O PANIC	91
30023	SOCIAL PHOBIA	91
30029	ISOLATED PHOBIAS NEC	91
3003	OBSESSIVE-COMPULSIVE DIS	91
3004	NEUROTIC DEPRESSION	91
3005	NEURASTHENIA	91
3006	DEPERSONALIZATION SYND	91
3007	HYPOCHONDRIASIS	91
30081	SOMATIZATION DISORDER	91
30089	NEUROTIC DISORDERS NEC	91
3009	NEUROTIC DISORDER NOS	91
3010	PARANOID PERSONALITY	91
30110	AFFECTIV PERSONALITY NOS	91
30111	CHRONIC HYPOMANIC PERSON	91
30112	CHR DEPRESSIVE PERSON	91
30113	CYCLOTHYMIC DISORDER	91
30120	SCHIZOID PERSONALITY NOS	91
30121	INTROVERTED PERSONALITY	91
30122	SCHIZOTYPAL PERSONALITY	91
3013	EXPLOSIVE PERSONALITY	91
3014	COMPULSIVE PERSONALITY	91
30150	HISTRIONIC PERSON NOS	91
30151	CHR FACTITIOUS ILLNESS	91

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
30159	HISTRIONIC PERSON NEC	91
3016	DEPENDENT PERSONALITY	91
3017	ANTISOCIAL PERSONALITY	91
30181	NARCISSISTIC PERSONALITY	91
30182	AVOIDANT PERSONALITY	91
30183	BORDERLINE PERSONALITY	91
30184	PASSIVE-AGGRESSIV PERSON	91
30189	PERSONALITY DISORDER NEC	91
3019	PERSONALITY DISORDER NOS	91
3020	EGO-DYSTONIC HOMOSEXLTY	91
3021	ZOOPHILIA	91
3022	PEDOPHILIA	91
3023	TRANSVESTISM	91
3024	EXHIBITIONISM	91
30250	TRANS-SEXUALISM NOS	91
30251	TRANS-SEXUALISM, ASEXUAL	91
30252	TRANS-SEXUAL, HOMOSEXUAL	91
30253	TRANS-SEX, HETEROSEXUAL	91
3026	PSYCHOSEX IDENTITY DIS	91
30270	PSYCHOSEXUAL DYSFUNC NOS	91
30271	INHIBITED SEXUAL DESIRE	91
30272	INHIBITED SEX EXCITEMENT	91
30273	INHIBITED FEMALE ORGASM	91
30274	INHIBITED MALE ORGASM	91
30275	PREMATURE EJACULATION	91
30276	FUNCTIONAL DYSPAREUNIA	91
30279	PSYCHOSEXUAL DYSFUNC NEC	91
30281	FETISHISM	91
30282	VOYEURISM	91
30283	SEXUAL MASOCHISM	91
30284	SEXUAL SADISM	91
30285	GEND IDEN DIS, ADOL/ADULT	91
30289	PSYCHOSEXUAL DIS NEC	91
3029	PSYCHOSEXUAL DIS NOS	91
30300	AC ALCOHOL INTOX-UNSPEC	91
30301	AC ALCOHOL INTOX-CONTIN	91
30302	AC ALCOHOL INTOX-EPISOD	91
30303	AC ALCOHOL INTOX-REMISS	91
30390	ALCOH DEP NEC/NOS-UNSPEC	91
30391	ALCOH DEP NEC/NOS-CONTIN	91
30392	ALCOH DEP NEC/NOS-EPISOD	91
30393	ALCOH DEP NEC/NOS-REMISS	91
30400	OPIOID DEPENDENCE-UNSPEC	91
30401	OPIOID DEPENDENCE-CONTIN	91
30402	OPIOID DEPENDENCE-EPISOD	91
30403	OPIOID DEPENDENCE-REMISS	91
30410	BARBITURAT DEPEND-UNSPEC	91
30411	BARBITURAT DEPEND-CONTIN	91
30412	BARBITURAT DEPEND-EPISOD	91
30413	BARBITURAT DEPEND-REMISS	91
30420	COCAINE DEPEND-UNSPEC	91
30421	COCAINE DEPEND-CONTIN	91
30422	COCAINE DEPEND-EPISODIC	91
30423	COCAINE DEPEND-REMISS	91
30430	CANNABIS DEPEND-UNSPEC	91
30431	CANNABIS DEPEND-CONTIN	91
30432	CANNABIS DEPEND-EPISODIC	91
30433	CANNABIS DEPEND-REMISS	91
30440	AMPHETAMIN DEPEND-UNSPEC	91
30441	AMPHETAMIN DEPEND-CONTIN	91
30442	AMPHETAMIN DEPEND-EPISOD	91
30443	AMPHETAMIN DEPEND-REMISS	91
30450	HALLUCINOGEN DEP-UNSPEC	91
30451	HALLUCINOGEN DEP-CONTIN	91
30452	HALLUCINOGEN DEP-EPISOD	91
30453	HALLUCINOGEN DEP-REMISS	91
30460	DRUG DEPEND NEC-UNSPEC	91
30461	DRUG DEPEND NEC-CONTIN	91
30462	DRUG DEPEND NEC-EPISODIC	91
30463	DRUG DEPEND NEC-IN REM	91
30470	OPIOID/OTHER DEP-UNSPEC	91
30471	OPIOID/OTHER DEP-CONTIN	91
30472	OPIOID/OTHER DEP-EPISOD	91
30473	OPIOID/OTHER DEP-REMISS	91
30480	COMB DRUG DEP NEC-UNSPEC	91
30481	COMB DRUG DEP NEC-CONTIN	91

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
30482	COMB DRUG DEP NEC-EPISOD	91
30483	COMB DRUG DEP NEC-REMISS	91
30490	DRUG DEPEND NOS-UNSPEC	91
30491	DRUG DEPEND NOS-CONTIN	91
30492	DRUG DEPEND NOS-EPISODIC	91
30493	DRUG DEPEND NOS-REMISS	91
30500	ALCOHOL ABUSE-UNSPEC	91
30501	ALCOHOL ABUSE-CONTINUOUS	91
30502	ALCOHOL ABUSE-EPISODIC	91
30503	ALCOHOL ABUSE-IN REMISS	91
3051	TOBACCO USE DISORDER	11
30510	TOBACCO USE DISORDER	11
30511	TOBACCO USE DISORDER	11
30512	TOBACCO USE DISORDER	11
30513	TOBACCO USE DISORDER	11
30520	CANNABIS ABUSE-UNSPEC	91
30521	CANNABIS ABUSE-CONTIN	91
30522	CANNABIS ABUSE-EPISODIC	91
30523	CANNABIS ABUSE-IN REMISS	91
30530	HALLUCINOG ABUSE-UNSPEC	91
30531	HALLUCINOG ABUSE-CONTIN	91
30532	HALLUCINOG ABUSE-EPISOD	91
30533	HALLUCINOG ABUSE-REMISS	91
30540	BARBITURATE ABUSE-UNSPEC	91
30541	BARBITURATE ABUSE-CONTIN	91
30542	BARBITURATE ABUSE-EPISOD	91
30543	BARBITURATE ABUSE-REMISS	91
30550	OPIOID ABUSE-UNSPEC	91
30551	OPIOID ABUSE-CONTINUOUS	91
30552	OPIOID ABUSE-EPISODIC	91
30553	OPIOID ABUSE-IN REMISS	91
30560	COCAINE ABUSE-UNSPEC	91
30561	COCAINE ABUSE-CONTINUOUS	91
30562	COCAINE ABUSE-EPISODIC	91
30563	COCAINE ABUSE-IN REMISS	91
30570	AMPHETAMINE ABUSE-UNSPEC	91
30571	AMPHETAMINE ABUSE-CONTIN	91
30572	AMPHETAMINE ABUSE-EPISOD	91
30573	AMPHETAMINE ABUSE-REMISS	91
30580	ANTIDEPRESS ABUSE-UNSPEC	91
30581	ANTIDEPRESS ABUSE-CONTIN	91
30582	ANTIDEPRESS ABUSE-EPISOD	91
30583	ANTIDEPRESS ABUSE-REMISS	91
30590	DRUG ABUSE NEC-UNSPEC	91
30591	DRUG ABUSE NEC-CONTIN	91
30592	DRUG ABUSE NEC-EPISODIC	91
30593	DRUG ABUSE NEC-IN REMISS	91
3060	PSYCHOGEN MUSCULSKEL DIS	24
3061	PSYCHOGENIC RESPIR DIS	33
3062	PSYCHOGEN CARDIOVASC DIS	36
3063	PSYCHOGENIC SKIN DISEASE	18
3064	PSYCHOGENIC GI DISEASE	41
30650	PSYCHOGENIC GU DIS NOS	53
30651	PSYCHOGENIC VAGINISMUS	56
30652	PSYCHOGENIC DYSMENORRHEA	56
30653	PSYCHOGENIC DYSURIA	53
30659	PSYCHOGENIC GU DIS NEC	53
3066	PSYCHOGEN ENDOCRINE DIS	82
3067	PSYCHOGENIC SENSORY DIS	91
3068	PSYCHOGENIC DISORDER NEC	91
3069	PSYCHOGENIC DISORDER NOS	91
3070	STAMMERING & STUTTERING	91
3071	ANOREXIA NERVOSA	91
30720	TIC DISORDER NOS	63
30721	TRANSIENT TIC, CHILDHOOD	63
30722	CHRONIC MOTOR TIC DIS	63
30723	GILLES TOURETTE DISORDER	63
3073	STEREOTYPED MOVEMENTS	91
30740	NONORGANIC SLEEP DIS NOS	91
30741	TRANSIENT INSOMNIA	91
30742	PERSISTENT INSOMNIA	91
30743	TRANSIENT HYPERSOMNIA	91
30744	PERSISTENT HYPERSOMNIA	91
30745	DISRUPT SLEEP-WAKE CYCLE	91
30746	SOMNAMBULISM/NGHT TERROR	91
30747	SLEEP STAGE DYSFUNC NEC	91

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
30748	REPETIT SLEEP INTRUSION	91
30749	NONORGANIC SLEEP DIS NEC	91
30750	EATING DISORDER NOS	91
30751	BULIMIA	91
30752	PICA	91
30753	PSYCHOGENIC RUMINATION	91
30754	PSYCHOGENIC VOMITING	91
30759	EATING DISORDER NEC	91
3076	ENURESIS	91
3077	ENCOPRESIS	91
30780	PSYCHOGENIC PAIN NOS	91
30781	TENSION HEADACHE	63
30789	PSYCHOGENIC PAIN NEC	91
3079	SPECIAL SYMPTOM NEC/NOS	91
3080	STRESS REACT, EMOTIONAL	91
3081	STRESS REACTION, FUGUE	91
3082	STRESS REACT, PSYCHOMOT	91
3083	ACUTE STRESS REACT NEC	91
3084	STRESS REACT, MIXED DIS	91
3089	ACUTE STRESS REACT NOS	91
3090	BRIEF DEPRESSIVE REACT	91
3091	PROLONG DEPRESSIVE REACT	91
30921	SEPARATION ANXIETY	91
30922	EMANCIPATION DISORDER	91
30923	ACADEMIC/WORK INHIBITION	91
30924	ADJ REACT-ANXIOUS MOOD	91
30928	ADJ REACT-MIXED EMOTION	91
30929	ADJ REACT-EMOTION NEC	91
3093	ADJUST REACT-CONDUCT DIS	91
3094	ADJ REACT-EMOTION/CONDUC	91
30981	PROLONG POSTTRAUM STRESS	91
30982	ADJUST REACT-PHYS SYMPT	91
30983	ADJUST REACT-WITHDRAWAL	91
30989	ADJUSTMENT REACTION NEC	91
3099	ADJUSTMENT REACTION NOS	91
3100	FRONTAL LOBE SYNDROME	91
3101	ORGANIC PERSONALITY SYND	91
3102	POSTCONCUSSION SYNDROME	63
3108	NONPSYCHOT BRAIN SYN NEC	91
3109	NONPSYCHOT BRAIN SYN NOS	91
311	DEPRESSIVE DISORDER NEC	91
31200	UNSOCIAL AGGRESS-UNSPEC	91
31201	UNSOCIAL AGGRESSION-MILD	91
31202	UNSOCIAL AGGRESSION-MOD	91
31203	UNSOCIAL AGGRESS-SEVERE	91
31210	UNSOCIAL UNAGGRESS-UNSP	91
31211	UNSOCIAL UNAGGRESS-MILD	91
31212	UNSOCIAL UNAGGRESS-MOD	91
31213	UNSOCIAL UNAGGR-SEVERE	91
31220	SOCIAL CONDUCT DIS-UNSP	91
31221	SOCIAL CONDUCT DIS-MILD	91
31222	SOCIAL CONDUCT DIS-MOD	91
31223	SOCIAL CONDUCT DIS-SEV	91
31230	IMPULSE CONTROL DIS NOS	91
31231	PATHOLOGICAL GAMBLING	91
31232	KLEPTOMANIA	91
31233	PYROMANIA	91
31234	INTERMITT EXPLOSIVE DIS	91
31235	ISOLATED EXPLOSIVE DIS	91
31239	IMPULSE CONTROL DIS NEC	91
3124	MIX DIS CONDUCT/EMOTION	91
3128	OTHER CONDUCT DISTURB*	91
31281	CNDCT DSRDR CHLDHD ONST	63
31282	CNDCT DSRDR ADLSCNT ONST	63
31289	OTHER CONDUCT DISORDER	63
3129	CONDUCT DISTURBANCE NOS	91
3130	OVERANXIOUS DISORDER	91
3131	MISERY & UNHAPPINESS DIS	91
31321	SHYNESS DISORDER-CHILD	91
31322	INTROVERTED DIS-CHILD	91
31323	ELECTIVE MUTISM	91
3133	RELATIONSHIP PROBLEMS	91
31381	OPPOSITIONAL DISORDER	91
31382	IDENTITY DISORDER	91
31383	ACADEMIC UNDERACHIEVMENT	91
31389	EMOTIONAL DIS CHILD NEC	91

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
3139	EMOTIONAL DIS CHILD NOS	91
31400	ATTN DEFIC NONHYPERACT	91
31401	ATTN DEFICIT W HYPERACT	91
3141	HYPERKINET W DEVEL DELAY	91
3142	HYPERKINETIC CONDUCT DIS	91
3148	OTHER HYPERKINETIC SYND	91
3149	HYPERKINETIC SYND NOS	91
31500	READING DISORDER NOS	91
31501	ALEXIA	91
31502	DEVELOPMENTAL DYSLEXIA	91
31509	READING DISORDER NEC	91
3151	ARITHMETICAL DISORDER	91
3152	OTH LEARNING DIFFICULTY	91
31531	DEVELOPMENT LANGUAGE DIS	91
31539	SPEECH/LANGUAGE DIS NEC	91
3154	COORDINATION DISORDER	91
3155	MIXED DEVELOPMENT DIS	91
3158	DEVELOPMENT DELAYS NEC	91
3159	DEVELOPMENT DELAY NOS	91
316	PSYCHIC FACTOR W OTH DIS	91
317	MILD MENTAL RETARDATION	91
3180	MOD MENTAL RETARDATION	91
3181	SEVERE MENTAL RETARDAT	91
3182	PROFOUND MENTAL RETARDAT	91
319	MENTAL RETARDATION NOS	91
3200	HEMOPHILUS MENINGITIS	63
3201	PNEUMOCOCCAL MENINGITIS	63
3202	STREPTOCOCCAL MENINGITIS	63
3203	STAPHYLOCOCC MENINGITIS	63
3207	MENING IN OTH BACT DIS	63
3208	BACTERIAL MENINGITIS NEC*	63
32081	ANAEROBIC MENINGITIS	63
32082	MNINGTS GRAM-NEG BCT NEC	63
32089	MENINGITIS OTH SPCF BACT	63
3209	BACTERIAL MENINGITIS NOS	63
3210	CRYPTOCOCCAL MENINGITIS	63
3211	MENING IN OTH FUNGAL DIS	63
3212	MENING IN OTH VIRAL DIS	63
3213	TRYPANOSOMIASIS MENINGIT	63
3214	MENINGIT D/T SARCOIDOSIS	63
3218	MENING IN OTH NONBAC DIS	63
3220	NONPYOGENIC MENINGITIS	63
3221	EOSINOPHILIC MENINGITIS	63
3222	CHRONIC MENINGITIS	63
3229	MENINGITIS NOS	63
3230	ENCEPHALIT IN VIRAL DIS	63
3231	RICKETTSIAL ENCEPHALITIS	63
3232	PROTOZOAL ENCEPHALITIS	63
3234	OTH ENCEPHALIT D/T INFEC	63
3235	POSTIMMUNIZAT ENCEPHALIT	63
3236	POSTINFECT ENCEPHALITIS	63
3237	TOXIC ENCEPHALITIS	63
3238	ENCEPHALITIS NEC	63
3239	ENCEPHALITIS NOS	63
3240	INTRACRANIAL ABSCESS	63
3241	INTRASPINAL ABSCESS	63
3249	CNS ABSCESS NOS	63
325	PHLEBITIS INTRCRAN SINUS	63
326	LATE EFF CNS ABSCESS	63
3300	LEUKODYSTROPHY	63
3301	CEREBRAL LIPIDOSES	63
3302	CEREB DEGEN IN LIPIDOSIS	63
3303	CERB DEG CHLD IN OTH DIS	63
3308	CEREB DEGEN IN CHILD NEC	63
3309	CEREB DEGEN IN CHILD NOS	63
3310	ALZHEIMER'S DISEASE	91
3311	PICK'S DISEASE	91
3312	SENILE DEGENERAT BRAIN	91
3313	COMMUNICAT HYDROCEPHALUS	63
3314	OBSTRUCTIV HYDROCEPHALUS	63
3317	CEREB DEGEN IN OTH DIS	63
33181	REYE'S SYNDROME	63
33189	CEREB DEGENERATION NEC	63
3319	CEREB DEGENERATION NOS	63
3320	PARALYSIS AGITANS	63
3321	SECONDARY PARKINSONISM	63

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
3330	DEGEN BASAL GANGLIA NEC	63
3331	TREMOR NEC	63
3332	MYOCLONUS	63
3333	TICS OF ORGANIC ORIGIN	63
3334	HUNTINGTON'S CHOREA	63
3335	CHOREA NEC	63
3336	IDIOPAT TORSION DYSTONIA	63
3337	SYMPTOM TORSION DYSTONIA	63
33381	BLEPHAROSPASM	68
33382	OROFACIAL DYSKINESIA	63
33383	SPASMODIC TORTICOLLIS	63
33384	ORGANIC WRITERS' CRAMP	63
33389	FRAGM TORSION DYSTON NEC	63
33390	EXTRAPYRAMIDAL DIS NOS	63
33391	STIFF-MAN SYNDROME	63
33392	NEUROLEPTIC MALGNT SYND	63
33393	BNIGN SHUDDERING ATTACKS	63
33399	EXTRAPYRAMIDAL DIS NEC	63
3340	FRIEDREICH'S ATAXIA	63
3341	HERED SPASTIC PARAPLEGIA	63
3342	PRIMARY CEREBELLAR DEGEN	63
3343	CEREBELLAR ATAXIA NEC	63
3344	CEREBEL ATAX IN OTH DIS	63
3348	SPINOCEREBELLAR DIS NEC	63
3349	SPINOCEREBELLAR DIS NOS	63
3350	WERDNIG-HOFFMANN DISEASE	63
33510	SPINAL MUSCL ATROPHY NOS	63
33511	KUGELBERG-WELANDER DIS	63
33519	SPINAL MUSCL ATROPHY NEC	63
33520	AMYOTROPHIC SCLEROSIS	63
33521	PROG MUSCULAR ATROPHY	63
33522	PROGRESSIVE BULBAR PALSY	63
33523	PSEUDOBULBAR PALSY	63
33524	PRIM LATERAL SCLEROSIS	63
33529	MOTOR NEURON DISEASE NEC	63
3358	ANT HORN CELL DIS NEC	63
3359	ANT HORN CELL DIS NOS	63
3360	SYRINGOMYELIA	63
3361	VASCULAR MYELOPATHIES	63
3362	COMB DEG CORD IN OTH DIS	63
3363	MYELOPATHY IN OTH DIS	63
3368	MYELOPATHY NEC	63
3369	SPINAL CORD DISEASE NOS	63
3370	IDIOPATH AUTO NEUROPATHY	63
3371	AUT NEUROPTHY IN OTH DIS	63
33720	UNSP RFLX SYMPTH DYSTRPH	63
33721	RFLX SYM DYSTRPH UP LIMB	63
33722	RFLX SYM DYSTRPH LWR LMB	63
33729	RFLX SYM DYSTRPH OTH ST	63
3379	AUTONOMIC NERVE DIS NEC	63
340	MULTIPLE SCLEROSIS	63
3410	NEUROMYELITIS OPTICA	63
3411	SCHILDER'S DISEASE	63
3418	CNS DEMYELINATION NEC	63
3419	CNS DEMYELINATION NOS	63
3420	FLACCID HEMIPLEGIA*	63
34200	FLCCD HMIPLGA UNSPF SIDE	63
34201	FLCCD HMIPLGA DOMNT SIDE	63
34202	FLCCD HMIPLG NONDMNT SDE	63
3421	SPASTIC HEMIPLEGIA*	63
34210	SPSTC HMIPLGA UNSPF SIDE	63
34211	SPSTC HMIPLGA DOMNT SIDE	63
34212	SPSTC HMIPLG NONDMNT SDE	63
34280	OT SP HMIPLGA UNSPF SIDE	63
34281	OT SP HMIPLGA DOMNT SIDE	63
34282	OT SP HMIPLG NONDMNT SDE	63
3429	HEMIPLEGIA NOS*	63
34290	UNSP HEMIPLGA UNSPF SIDE	63
34291	UNSP HEMIPLGA DOMNT SIDE	63
34292	UNSP HMIPLGA NONDMNT SDE	63
3430	CONGENITAL DIPLEGIA	63
3431	CONGENITAL HEMIPLEGIA	63
3432	CONGENITAL QUADRIPLEGIA	63
3433	CONGENITAL MONOPLEGIA	63
3434	INFANTILE HEMIPLEGIA	63
3438	CEREBRAL PALSY NEC	63

*ICD–9 Codes preceded by an asterisk are codes that are not valid as a reason for the visit.

ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
3439	CEREBRAL PALSY NOS	63
3440	QUADRIPLEGIA NOS*	63
34400	QUADRIPLEGIA, UNSPECIFD	63
34401	QUADRPLG C1-C4, COMPLETE	63
34402	QUADRPLG C1-C4, INCOMPLT	63
34403	QUADRPLG C5-C7, COMPLETE	63
34404	QUADRPLG C5-C7, INCOMPLT	63
34409	OTHER QUADRIPLEGIA	63
3441	PARAPLEGIA NOS	63
3442	DIPLEGIA OF UPPER LIMBS	63
3443	MONOPLEGIA OF LOWER LIMB*	63
34430	MONPLGA LWR LMB UNSP SDE	63
34431	MONPLGA LWR LMB DMNT SDE	63
34432	MNPLG LWR LMB NONDMNT SD	63
3444	MONOPLEGIA OF UPPER LIMB*	63
34440	MONPLGA UPR LMB UNSP SDE	63
34441	MONPLGA UPR LMB DMNT SDE	63
34442	MNPLG UPR LMB NONDMNT SD	63
3445	MONOPLEGIA NOS	63
34460	CAUDA EQUINA SYND NOS	63
34461	NEUROGENIC BLADDER	53
3448	PARALYTIC SYNDROMES NEC*	63
34481	LOCKED-IN STATE	78
34489	OTH SPCF PARALYTIC SYND	63
3449	PARALYSIS NOS	63
34500	GEN NONCV EP W/O INTR EP	63
34501	GEN NONCONV EP W INTR EP	63
34510	GEN CNV EPIL W/O INTR EP	63
34511	GEN CNV EPIL W INTR EPIL	63
3452	PETIT MAL STATUS	78
3453	GRAND MAL STATUS	78
34540	PSYMOTR EPIL W/O INT EPI	63
34541	PSYMOTR EPIL W INTR EPIL	63
34550	PART EPIL W/O INTR EPIL	63
34551	PART EPIL W INTR EPIL	63
34560	INF SPASM W/O INTR EPIL	63
34561	INF SPASM W INTRACT EPIL	63
34570	EPIL PAR CONT W/O INT EP	63
34571	EPIL PAR CONT W INTR EPI	63
34580	EPILEP NEC W/O INTR EPIL	63
34581	EPILEPSY NEC W INTR EPIL	63
34590	EPILEP NOS W/O INTR EPIL	63
34591	EPILEPSY NOS W INTR EPIL	63
3460	CLASSICAL MIGRAINE*	63
34600	CLSC MIGRNE WO NTRC MGRN	63
34601	CLSC MGRN W NTRC MGR STD	63
3461	COMMON MIGRAINE*	63
34610	COMN MIGRNE WO NTRC MGRN	63
34611	COMN MGRN W NTRC MGR STD	63
3462	VARIANTS OF MIGRAINE*	63
34620	VRNT MIGRNE WO NTRC MGRN	63
34621	VRNT MGRN W NTRC MGR STD	63
3468	MIGRAINE NEC*	63
34680	OTHR MIGRNE WO NTRC MGRN	63
34681	OTHR MGRN W NTRC MGR STD	63
3469	MIGRAINE NOS*	63
34690	MIGRNE UNSP WO NTRC MGRN	63
34691	MGRN UNSP W NTRC MGR STD	63
347	CATAPLEXY AND NARCOLEPSY	63
3480	CEREBRAL CYSTS	63
3481	ANOXIC BRAIN DAMAGE	63
3482	PSEUDOTUMOR CEREBRI	63
3483	ENCEPHALOPATHY NOS	63
3484	COMPRESSION OF BRAIN	63
3485	CEREBRAL EDEMA	63
3488	BRAIN CONDITIONS NEC	63
3489	BRAIN CONDITION NOS	63
3490	LUMBAR PUNCTURE REACTION	63
3491	COMPLICATION CNS DEVICE	63
3492	DISORDER OF MENINGES NEC	63
34981	CEREBROSPINAL RHINORRHEA	63
34982	TOXIC ENCEPHALOPATHY	63
34989	CNS DISORDER NEC	63
3499	CNS DISORDER NOS	63
3501	TRIGEMINAL NEURALGIA	63
3502	ATYPICAL FACE PAIN	63

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
3508	TRIGEMINAL NERVE DIS NEC	63
3509	TRIGEMINAL NERVE DIS NOS	63
3510	BELL'S PALSY	63
3511	GENICULATE GANGLIONITIS	63
3518	FACIAL NERVE DIS NEC	63
3519	FACIAL NERVE DIS NOS	63
3520	OLFACTORY NERVE DISORDER	63
3521	GLOSSOPHARYNG NEURALGIA	63
3522	GLOSSOPHAR NERVE DIS NEC	63
3523	PNEUMOGASTRIC NERVE DIS	63
3524	ACCESSORY NERVE DISORDER	63
3525	HYPOGLOSSAL NERVE DIS	63
3526	MULT CRANIAL NERVE PALSY	63
3529	CRANIAL NERVE DIS NOS	63
3530	BRACHIAL PLEXUS LESIONS	63
3531	LUMBOSACRAL PLEX LESION	63
3532	CERVICAL ROOT LESION NEC	63
3533	THORACIC ROOT LESION NEC	63
3534	LUMBSACRAL ROOT LES NEC	63
3535	NEURALGIC AMYOTROPHY	63
3536	PHANTOM LIMB (SYNDROME)	63
3538	NERV ROOT/PLEXUS DIS NEC	63
3539	NERV ROOT/PLEXUS DIS NOS	63
3540	CARPAL TUNNEL SYNDROME	63
3541	MEDIAN NERVE LESION NEC	63
3542	ULNAR NERVE LESION	63
3543	RADIAL NERVE LESION	63
3544	CAUSALGIA UPPER LIMB	63
3545	MONONEURITIS MULTIPLEX	63
3548	MONONEURITIS ARM NEC	63
3549	MONONEURITIS ARM NOS	63
3550	SCIATIC NERVE LESION	63
3551	MERALGIA PARESTHETICA	63
3552	FEMORAL NERVE LESION NEC	63
3553	LAT POPLITEAL NERVE LES	63
3554	MED POPLITEAL NERVE LES	63
3555	TARSAL TUNNEL SYNDROME	63
3556	PLANTAR NERVE LESION	63
3557	MONONEURITIS LEG NEC*	63
35571	CAUSALGIA LOWER LIMB	63
35579	OTH MONONEUR LOWER LIMB	63
3558	MONONEURITIS LEG NOS	63
3559	MONONEURITIS NOS	63
3560	HERED PERIPH NEUROPATHY	63
3561	PERONEAL MUSCLE ATROPHY	63
3562	HERED SENSORY NEUROPATHY	63
3563	REFSUM'S DISEASE	63
3564	IDIO PROG POLYNEUROPATHY	63
3568	IDIO PERIPH NEURPTHY NEC	63
3569	IDIO PERIPH NEURPTHY NOS	63
3570	AC INFECT POLYNEURITIS	63
3571	NEURPTHY IN COL VASC DIS	63
3572	NEUROPATHY IN DIABETES	63
3573	NEUROPATHY IN MALIG DIS	63
3574	NEUROPATHY IN OTHER DIS	63
3575	ALCOHOLIC POLYNEUROPATHY	63
3576	NEUROPATHY DUE TO DRUGS	63
3577	NEURPTHY TOXIC AGENT NEC	63
3578	INFLAM/TOX NEUROPTHY NEC	63
3579	INFLAM/TOX NEUROPTHY NOS	63
3580	MYASTHENIA GRAVIS	63
3581	MYASTHENIA IN OTH DIS	63
3582	TOXIC MYONEURAL DISORDER	63
3588	MYONEURAL DISORDERS NEC	63
3589	MYONEURAL DISORDERS NOS	63
3590	CONG HERED MUSC DYSTRPHY	63
3591	HERED PROG MUSC DYSTRPHY	63
3592	MYOTONIC DISORDERS	63
3593	FAMIL PERIODIC PARALYSIS	63
3594	TOXIC MYOPATHY	63
3595	MYOPATHY IN ENDOCRIN DIS	63
3596	INFL MYOPATHY IN OTH DIS	63
3598	MYOPATHY NEC	63
3599	MYOPATHY NOS	63
36000	PURULENT ENDOPHTHALM NOS	68
36001	ACUTE ENDOPHTHALMITIS	68

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
36002	PANOPHTHALMITIS	68
36003	CHRONIC ENDOPHTHALMITIS	68
36004	VITREOUS ABSCESS	68
36011	SYMPATHETIC UVEITIS	68
36012	PANUVEITIS	68
36013	PARASITIC ENDOPHTHAL NOS	68
36014	OPHTHALMIA NODOSA	68
36019	ENDOPHTHALMITIS NEC	68
36020	DEGENERAT GLOBE DIS NOS	68
36021	PROGRESSIVE HIGH MYOPIA	68
36023	SIDEROSIS	68
36024	OTHER METALLOSIS, EYE	68
36029	DEGENERATIVE GLOBE NEC	68
36030	HYPOTONY NOS, EYE	68
36031	PRIMARY HYPOTONY	68
36032	HYPOTONY DUE TO FISTULA	68
36033	HYPOTONY W EYE DIS NEC	68
36034	FLAT ANTERIOR CHAMBER	68
36040	DEGENERATION OF EYE NOS	68
36041	BLIND HYPOTENSIVE EYE	68
36042	BLIND HYPERTENSIVE EYE	68
36043	HEMOPHTHALMOS	68
36044	LEUCOCORIA	68
36050	OLD MAGNET FB, EYE NOS	68
36051	OLD MAGNET FB, ANT CHAMB	68
36052	OLD MAGNET FB, IRIS	68
36053	OLD MAGNET FB, LENS	68
36054	OLD MAGNET FB, VITREOUS	68
36055	OLD MAGNET FB, POST WALL	68
36059	OLD MAGNET FB, EYE NEC	68
36060	INTRAOCULAR FB NOS	68
36061	FB IN ANTERIOR CHAMBER	68
36062	FB IN IRIS OR CILIARY	68
36063	FOREIGN BODY IN LENS	68
36064	FOREIGN BODY IN VITREOUS	68
36065	FB IN POSTERIOR WALL	68
36069	INTRAOCULAR FB NEC	68
36081	LUXATION OF GLOBE	68
36089	DISORDER OF GLOBE NEC	68
3609	DISORDER OF GLOBE NOS	68
36100	DETACHMNT W DEFECT NOS	68
36101	PART DETACH-SINGL DEFEC	68
36102	PART DETACH-MULT DEFECT	68
36103	PART DETACH-GIANT TEAR	68
36104	PART DETACH-DIALYSIS	68
36105	RECENT DETACHMENT, TOTAL	68
36106	OLD DETACHMENT, PARTIAL	68
36107	OLD DETACHMENT, TOTAL	68
36110	RETINOSCHISIS NOS	68
36111	FLAT RETINOSCHISIS	68
36112	BULLOUS RETINOSCHISIS	68
36113	PRIMARY RETINAL CYSTS	68
36114	SECONDARY RETINAL CYSTS	68
36119	RETINOSHISIS OR CYST NEC	68
3612	SEROUS RETINA DETACHMENT	68
36130	RETINAL DEFECT NOS	68
36131	ROUND HOLE OF RETINA	68
36132	HORSESHOE TEAR OF RETINA	68
36133	MULT DEFECTS OF RETINA	68
36181	RETINAL TRACTION DETACH	68
36189	RETINAL DETACHMENT NEC	68
3619	RETINAL DETACHMENT NOS	68
36201	DIABETIC RETINOPATHY NOS	68
36202	PROLIF DIAB RETINOPATHY	68
36210	BACKGRND RETINOPATHY NOS	68
36211	HYPERTENSIVE RETINOPATHY	68
36212	EXUDATIVE RETINOPATHY	68
36213	RETINAL VASCULAR CHANGES	68
36214	RETINA MICROANEURYSM NOS	68
36215	RETINAL TELANGIECTASIA	68
36216	RETINAL NEOVASCULAR NOS	68
36217	RETINAL VARICES	68
36218	RETINAL VASCULITIS	68
36221	RETROLENTAL FIBROPLASIA	68
36229	PROLIF RETINOPATHY NEC	68
36230	RETINAL VASC OCCLUS NOS	68

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
36231	CENT RETINA ARTERY OCCLU	68
36232	ARTERIAL BRANCH OCCLUS	68
36233	PART ARTERIAL OCCLUSION	68
36234	TRANSIENT ARTERIAL OCCLU	68
36235	CENT RETINAL VEIN OCCLUS	68
36236	VENOUS TRIBUTARY OCCLUS	68
36237	RETINA VENOUS ENGORGEMNT	68
36240	RETINA LAYER SEPARAT NOS	68
36241	CENT SEROUS RETINOPATHY	68
36242	SEROUS DETACH PIGM EPITH	68
36243	HEM DETACH PIGMNT EPITH	68
36250	MACULAR DEGENERATION NOS	68
36251	NONEXUDAT MACULAR DEGEN	68
36252	EXUDATIVE MACULAR DEGEN	68
36253	CYSTOID MACULAR DEGEN	68
36254	MACULAR CYST OR HOLE	68
36255	TOXIC MACULOPATHY	68
36256	MACULAR PUCKERING	68
36257	DRUSEN (DEGENERATIVE)	68
36260	PERIPH RETINA DEGEN NOS	68
36261	PAVING STONE DEGENERAT	68
36262	MICROCYSTOID DEGENERAT	68
36263	LATTICE DEGENERATION	68
36264	SENILE RETICULAR DEGEN	68
36265	SECONDRY PIGMENT DEGEN	68
36266	SEC VITREORETINA DEGEN	68
36270	HERED RETIN DYSTRPHY NOS	68
36271	RET DYSTRPH IN LIPIDOSES	68
36272	RET DYSTRPH IN SYST DIS	68
36273	VITREORETINAL DYSTROPHY	68
36274	PIGMENT RETINA DYSTROPHY	68
36275	SENSORY RETINA DYSTROPHY	68
36276	VITELLIFORM DYSTROPHY	68
36277	BRUCH MEMBRANE DYSTROPHY	68
36281	RETINAL HEMORRHAGE	68
36282	RETINA EXUDATES/DEPOSITS	68
36283	RETINAL EDEMA	68
36284	RETINAL ISCHEMIA	68
36285	RETINAL NERV FIBER DEFEC	68
36289	RETINAL DISORDERS NEC	68
3629	RETINAL DISORDER NOS	68
36300	FOCAL CHORIORETINIT NOS	68
36301	JUXTAPAP FOC CHOROIDITIS	68
36303	FOC CHOROIDITIS POST NEC	68
36304	PERIPH FOCAL CHOROIDITIS	68
36305	JUXTAPAP FOCAL RETINITIS	68
36306	MACULAR FOCAL RETINITIS	68
36307	FOC RETINITIS POST NEC	68
36308	PERIPH FOCAL RETINITIS	68
36310	DISSEM CHORIORETINIT NOS	68
36311	DISSEM CHOROIDITIS, POST	68
36312	PERIPH DISEM CHOROIDITIS	68
36313	GEN DISSEM CHOROIDITIS	68
36314	METASTAT DISSEM RETINIT	68
36315	PIGMENT EPITHELIOPATHY	68
36320	CHORIORETINITIS NOS	68
36321	PARS PLANITIS	68
36322	HARADA'S DISEASE	68
36330	CHORIORETINAL SCAR NOS	68
36331	SOLAR RETINOPATHY	68
36332	MACULAR SCARS NEC	68
36333	POSTERIOR POLE SCAR NEC	68
36334	PERIPHERAL RETINAL SCARS	68
36335	DISSEMINATED RETINA SCAR	68
36340	CHOROIDAL DEGEN NOS	68
36341	SENILE ATROPHY, CHOROID	68
36342	DIFUS SEC ATROPH CHOROID	68
36343	ANGIOID STREAKS, CHOROID	68
36350	HERED CHOROID ATROPH NOS	68
36351	PRT CIRCMPAP CHOROID DYS	68
36352	TOT CIRCMPAP CHOROID DYS	68
36353	PART CENT CHOROID DYSTR	68
36354	TOT CENT CHOROID ATROPHY	68
36355	CHOROIDEREMIA	68
36356	PRT GEN CHOROID DYST NEC	68
36357	TOT GEN CHOROID DYST NEC	68

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
36361	CHOROIDAL HEMORRHAGE NOS	68
36362	EXPULSIVE CHOROID HEMORR	68
36363	CHOROIDAL RUPTURE	68
36370	CHOROIDAL DETACHMENT NOS	68
36371	SEROUS CHOROID DETACHMNT	68
36372	HEMORR CHOROID DETACHMNT	68
3638	DISORDERS OF CHOROID NEC	68
3639	CHOROIDAL DISORDER NOS	68
36400	ACUTE IRIDOCYCLITIS NOS	68
36401	PRIMARY IRIDOCYCLITIS	68
36402	RECURRENT IRIDOCYCLITIS	68
36403	SECONDRY IRITIS, INFECT	68
36404	SECOND IRITIS, NONINFEC	68
36405	HYPOPYON	68
36410	CHR IRIDOCYCLITIS NOS	68
36411	CHR IRIDOCYL IN OTH DIS	68
36421	FUCH HETROCHROM CYCLITIS	68
36422	GLAUCOMATOCYCLIT CRISES	68
36423	LENS-INDUCED IRIDOCYCLIT	68
36424	VOGT-KOYANAGI SYNDROME	68
3643	IRIDOCYCLITIS NOS	68
36441	HYPHEMA	68
36442	RUBEOSIS IRIDIS	68
36451	PROGRESSIVE IRIS ATROPHY	68
36452	IRIDOSCHISIS	68
36453	PIGMENT IRIS DEGENERAT	68
36454	PUPILLARY MARGIN DEGEN	68
36455	MIOTIC CYST PUPIL MARGIN	68
36456	DEGEN CHAMBER ANGLE	68
36457	DEGEN CILIARY BODY	68
36459	IRIS ATROPHY NEC	68
36460	IDIOPATHIC CYSTS	68
36461	IMPLANTATION CYSTS	68
36462	EXUD CYST IRIS/ANT CHAMB	68
36463	PRIMARY CYST PARS PLANA	68
36464	EXUDAT CYST PARS PLANA	68
36470	ADHESIONS OF IRIS NOS	68
36471	POSTERIOR SYNECHIAE	68
36472	ANTERIOR SYNECHIAE	68
36473	GONIOSYNECHIAE	68
36474	PUPILLARY MEMBRANES	68
36475	PUPILLARY ABNORMALITIES	68
36476	IRIDODIALYSIS	68
36477	RECESSION, CHAMBER ANGLE	68
3648	IRIS/CILIARY DIS NEC	68
3649	IRIS/CILIARY DIS NOS	68
36500	PREGLAUCOMA NOS	68
36501	OPN ANGL W BORDERLN FIND	68
36502	ANATOMICAL NARROW ANGLE	68
36503	STEROID RESPONDERS	68
36504	OCULAR HYPERTENSION	68
36510	OPEN-ANGLE GLAUCOMA NOS	68
36511	PRIM OPEN ANGLE GLAUCOMA	68
36512	LOW TENSION GLAUCOMA	68
36513	PIGMENTARY GLAUCOMA	68
36514	GLAUCOMA OF CHILDHOOD	68
36515	RESIDUAL OPN ANG GLAUCMA	68
36520	PRIM ANGL-CLOS GLAUC NOS	68
36521	INTERMIT ANGL-CLOS GLAUC	68
36522	ACUTE ANGL-CLOS GLAUCOMA	68
36523	CHR ANGLE-CLOS GLAUCOMA	68
36524	RESIDUAL ANGL-CLOS GLAUC	68
36531	GLAUC STAGE-STER INDUCED	68
36532	GLAUC RESID-STER INDUCED	68
36541	GLAUC W CHAMB ANGLE ANOM	68
36542	GLAUCOMA W IRIS ANOMALY	68
36543	GLAUC W ANT SEG ANOM NEC	68
36544	GLAUCOMA W SYSTEMIC SYND	68
36551	PHACOLYTIC GLAUCOMA	68
36552	PSEUDOEXFOLIAT GLAUCOMA	68
36559	GLAUCOMA W LENS DIS NEC	68
36560	GLAUC W OCULAR DIS NOS	68
36561	GLAUC W PUPILLARY BLOCK	68
36562	GLAUCOMA W OCULAR INFLAM	68
36563	GLAUCOMA W VASCULAR DIS	68
36564	GLAUCOMA W TUMOR OR CYST	68

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
36565	GLAUCOMA W OCULAR TRAUMA	68
36581	HYPERSECRETION GLAUCOMA	68
36582	GLAUC W INC EPISCL PRESS	68
36589	GLAUCOMA NEC	68
3659	GLAUCOMA NOS	68
36600	NONSENILE CATARACT NOS	68
36601	ANT SUBCAPS POL CATARACT	68
36602	POST SUBCAPS POL CATARCT	68
36603	CORTICAL CATARACT	68
36604	NUCLEAR CATARACT	68
36609	NONSENILE CATARACT NEC	68
36610	SENILE CATARACT NOS	68
36611	PSEUDOEXFOL LENS CAPSULE	68
36612	INCIPIENT CATARACT	68
36613	ANT SUBCAPS SENILE CATAR	68
36614	POST SUBCAP SENILE CATAR	68
36615	CORTICAL SENILE CATARACT	68
36616	SENILE NUCLEAR CATARACT	68
36617	MATURE CATARACT	68
36618	HYPERMATURE CATARACT	68
36619	SENILE CATARACT NEC	68
36620	TRAUMATIC CATARACT NOS	68
36621	LOCAL TRAUMATIC OPACITY	68
36622	TOTAL TRAUMATIC CATARACT	68
36623	PART RESOLV TRAUM CATAR	68
36630	CATARACTA COMPLICATA NOS	68
36631	GLAUCOMATOUS FLECKS	68
36632	CATARACT IN INFLAM DIS	68
36633	CATARACT W NEOVASCULIZAT	68
36634	CATARACT IN DEGEN DIS	68
36641	DIABETIC CATARACT	68
36642	TETANIC CATARACT	68
36643	MYOTONIC CATARACT	68
36644	CATARACT W SYNDROME NEC	68
36645	TOXIC CATARACT	68
36646	CATARACT W RADIATION	68
36650	AFTER-CATARACT NOS	68
36651	SOEMMERING'S RING	68
36652	AFTER-CATARACT NEC	68
36653	AFTR-CATAR OBSCUR VISION	68
3668	CATARACT NEC	68
3669	CATARACT NOS	68
3670	HYPERMETROPIA	68
3671	MYOPIA	68
36720	ASTIGMATISM NOS	68
36721	REGULAR ASTIGMATISM	68
36722	IRREGULAR ASTIGMATISM	68
36731	ANISOMETROPIA	68
36732	ANISEIKONIA	68
3674	PRESBYOPIA	68
36751	PARESIS OF ACCOMMODATION	68
36752	TOT INTERN OPHTHALMOPLEG	68
36753	SPASM OF ACCOMMODATION	68
36781	TRANSIENT REFRACT CHANGE	68
36789	REFRACTION DISORDER NEC	68
3679	REFRACTION DISORDER NOS	68
36800	AMBLYOPIA NOS	68
36801	STRABISMIC AMBLYOPIA	68
36802	DEPRIVATION AMBLYOPIA	68
36803	REFRACTIVE AMBLYOPIA	68
36810	SUBJ VISUAL DISTURB NOS	68
36811	SUDDEN VISUAL LOSS	68
36812	TRANSIENT VISUAL LOSS	68
36813	VISUAL DISCOMFORT	68
36814	DISTORTION OF SHAPE/SIZE	68
36815	VISUAL DISTORTIONS NEC	68
36816	PSYCHOPHYSIC VISUAL DIST	68
3682	DIPLOPIA	68
36830	BINOCULAR VISION DIS NOS	68
36831	BINOCULAR VIS SUPPRESS	68
36832	VISUAL PERCEPT W/O FUSN	68
36833	FUSION W DEF STEREOPSIS	68
36834	ABN RETINA CORRESPOND	68
36840	VISUAL FIELD DEFECT NOS	68
36841	CENTRAL SCOTOMA	68
36842	SCOTOMA OF BLIND SPOT	68

*ICD–9 Codes preceded by an asterisk are codes that are not valid as a reason for the visit.

ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
36843	SECTOR OR ARCUATE DEFECT	68
36844	VISUAL FIELD DEFECT NEC	68
36845	GEN VISUAL CONTRACTION	68
36846	HOMONYMOUS HEMIANOPSIA	68
36847	HETERONYMOUS HEMIANOPSIA	68
36851	PROTAN DEFECT	68
36852	DEUTAN DEFECT	68
36853	TRITAN DEFECT	68
36854	ACHROMATOPSIA	68
36855	ACQ COLOR DEFICIENCY	68
36859	COLOR DEFICIENCY NEC	68
36860	NIGHT BLINDNESS NOS	68
36861	CONGEN NIGHT BLINDNESS	68
36862	ACQUIRED NIGHT BLINDNESS	68
36863	ABN DARK ADAPTAT CURVE	68
36869	NIGHT BLINDNESS NEC	68
3688	VISUAL DISTURBANCES NEC	68
3689	VISUAL DISTURBANCE NOS	68
36900	BOTH EYES BLIND-WHO DEF	68
36901	TOT IMPAIRMENT-BOTH EYES	68
36902	ONE EYE-NEAR TOT/OTH-NOS	68
36903	ONE EYE-NEAR TOT/OTH-TOT	68
36904	NEAR-TOT IMPAIR-BOTH EYE	68
36905	ONE EYE-PROFOUND/OTH-NOS	68
36906	ONE EYE-PROFOUND/OTH-TOT	68
36907	ONE EYE-PRFND/OTH-NR TOT	68
36908	PROFOUND IMPAIR BOTH EYE	68
36910	BLINDNESS/LOW VISION	68
36911	1 EYE-SEV/OTH-BLIND NOS	68
36912	ONE EYE-SEVERE/OTH-TOTAL	68
36913	ONE EYE-SEV/OTH-NEAR TOT	68
36914	ONE EYE-SEV/OTH-PRFND	68
36915	ONE EYE-MOD/OTH-BLIND	68
36916	ONE EYE-MODERATE/OTH-TOT	68
36917	ONE EYE-MOD/OTH-NEAR TOT	68
36918	ONE EYE-MOD/OTH-PROFOUND	68
36920	LOW VISION, 2 EYES NOS	68
36921	ONE EYE-SEVERE/OTH-NOS	68
36922	SEVERE IMPAIR-BOTH EYES	68
36923	ONE EYE-MODERATE/OTH-NOS	68
36924	ONE EYE-MODERATE/OTH-SEV	68
36925	MODERATE IMPAIR-BOTH EYE	68
3693	BLINDNESS NOS, BOTH EYES	68
3694	LEGAL BLINDNESS-USA DEF	68
36960	BLINDNESS, ONE EYE	68
36961	ONE EYE-TOTAL/OTH-UNKNWN	68
36962	ONE EYE-TOT/OTH-NEAR NOR	68
36963	ONE EYE-TOTAL/OTH-NORMAL	68
36964	ONE EYE-NEAR TOT/OTH-NOS	68
36965	NEAR-TOT IMP/NEAR-NORMAL	68
36966	NEAR-TOTAL IMPAIR/NORMAL	68
36967	ONE EYE-PRFOUND/OTH-UNKN	68
36968	PROFND IMPAIR/NEAR NORM	68
36969	PROFOUND IMPAIR/NORMAL	68
36970	LOW VISION, ONE EYE	68
36971	ONE EYE-SEVERE/OTH-UNKNW	68
36972	ONE EYE-SEV/OTH-NR NORM	68
36973	ONE EYE-SEVERE/OTH-NORM	68
36974	ONE EYE-MOD/OTHER-UNKNWN	68
36975	ONE EYE-MOD/OTH-NR NORM	68
36976	ONE EYE-MOD/OTH NORMAL	68
3698	VISUAL LOSS, ONE EYE NOS	68
3699	VISUAL LOSS NOS	68
37000	CORNEAL ULCER NOS	68
37001	MARGINAL CORNEAL ULCER	68
37002	RING CORNEAL ULCER	68
37003	CENTRAL CORNEAL ULCER	68
37004	HYPOPYON ULCER	68
37005	MYCOTIC CORNEAL ULCER	68
37006	PERFORATED CORNEAL ULCER	68
37007	MOOREN'S ULCER	68
37020	SUPERFIC KERATITIS NOS	68
37021	PUNCTATE KERATITIS	68
37022	MACULAR KERATITIS	68
37023	FILAMENTARY KERATITIS	68
37024	PHOTOKERATITIS	68

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
37031	PHLYCTEN KERATOCONJUNCT	68
37032	LIMBAR KERATOCONJUNCTIV	68
37033	KERATOCONJUNCTIVIT SICCA	68
37034	EXPSURE KERATOCONJUNCTIV	68
37035	NEUROTROPH KERATOCONJUNC	68
37040	KERATOCONJUNCTIVITIS NOS	68
37044	KERATITIS IN EXANTHEMA	68
37049	KERATOCONJUNCTIVITIS NEC	68
37050	INTERSTIT KERATITIS NOS	68
37052	DIFFUS INTERSTIT KERATIT	68
37054	SCLEROSING KERATITIS	68
37055	CORNEAL ABSCESS	68
37059	INTERSTIT KERATITIS NEC	68
37060	CORNEA NEOVASCULARIZ NOS	68
37061	LOCAL VASCULARIZA CORNEA	68
37062	CORNEAL PANNUS	68
37063	DEEP VASCULARIZA CORNEA	68
37064	CORNEAL GHOST VESSELS	68
3708	KERATITIS NEC	68
3709	KERATITIS NOS	68
37100	CORNEAL OPACITY NOS	68
37101	MINOR OPACITY OF CORNEA	68
37102	PERIPH OPACITY OF CORNEA	68
37103	CENTRAL OPACITY, CORNEA	68
37104	ADHERENT LEUCOMA	68
37105	PHTHISICAL CORNEA	68
37110	CORNEAL DEPOSIT NOS	68
37111	ANT CORNEA PIGMENTATION	68
37112	STROMAL CORNEA PIGMENT	68
37113	POST CORNEA PIGMENTATION	68
37114	KAYSER-FLEISCHER RING	68
37115	OTH DEPOSIT W METAB DIS	68
37116	ARGENTOUS CORNEA DEPOSIT	68
37120	CORNEAL EDEMA NOS	68
37121	IDIOPATHIC CORNEAL EDEMA	68
37122	SECONDARY CORNEAL EDEMA	68
37123	BULLOUS KERATOPATHY	68
37124	EDEMA D/T CONTACT LENS	68
37130	CORNEA MEMB CHANGE NOS	68
37131	FOLD OF BOWMAN MEMBRANE	68
37132	FOLD IN DESCEMET MEMBRAN	68
37133	RUPTURE DESCEMET MEMBRAN	68
37140	CORNEAL DEGENERATION NOS	68
37141	SENILE CORNEAL CHANGES	68
37142	RECURRENT CORNEA EROSION	68
37143	BAND-SHAPED KERATOPATHY	68
37144	CALCER CORNEA DEGEN NEC	68
37145	KERATOMALACIA NOS	68
37146	NODULAR CORNEA DEGEN	68
37148	PERIPHERAL CORNEA DEGEN	68
37149	CORNEA DEGENERATION NEC	68
37150	CORNEAL DYSTROPHY NOS	68
37151	JUV EPITH CORNEA DYSTRPH	68
37152	ANT CORNEA DYSTROPHY NEC	68
37153	GRANULAR CORNEA DYSTRPHY	68
37154	LATTICE CORNEA DYSTROPHY	68
37155	MACULAR CORNEA DYSTROPHY	68
37156	STROM CORNEA DYSTRPH NEC	68
37157	ENDOTHEL CORNEA DYSTRPHY	68
37158	POST CORNEA DYSTRPHY NEC	68
37160	KERATOCONUS NOS	68
37161	KERATOCONUS, STABLE	68
37162	KERATOCONUS, AC HYDROPS	68
37170	CORNEAL DEFORMITY NOS	68
37171	CORNEAL ECTASIA	68
37172	DESCEMETOCELE	68
37173	CORNEAL STAPHYLOMA	68
37181	CORNEAL ANESTHESIA	68
37182	CORNEAL DSDR CONTCT LENS	68
37189	CORNEAL DISORDER NEC	68
3719	CORNEAL DISORDER NOS	68
37200	ACUTE CONJUNCTIVITIS NOS	68
37201	SEROUS CONJUNCTIVITIS	68
37202	AC FOLLIC CONJUNCTIVITIS	68
37203	MUCOPUR CONJUNCTIVIT NEC	68
37204	PSEUDOMEMB CONJUNCTIVIT	68

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
37205	AC ATOPIC CONJUNCTIVITIS	68
37210	CHR CONJUNCTIVITIS NOS	68
37211	SIMPL CHR CONJUNCTIVITIS	68
37212	CHR FOLLIC CONJUNCTIVIT	68
37213	VERNAL CONJUNCTIVITIS	68
37214	CHR ALLRG CONJUNCTIV NEC	68
37215	PARASITIC CONJUNCTIVITIS	68
37220	BLEPHAROCONJUNCTIVIT NOS	68
37221	ANGULAR BLEPHAROCONJUNCT	68
37222	CONTACT BLEPHAROCONJUNCT	68
37230	CONJUNCTIVITIS NOS	68
37231	ROSACEA CONJUNCTIVITIS	68
37233	MUCOCUTAN DIS CONJUNCTIV	68
37239	CONJUNCTIVITIS NEC	68
37240	PTERYGIUM NOS	68
37241	PERIPH STATION PTERYGIUM	68
37242	PERIPH PROGESS PTERYGIUM	68
37243	CENTRAL PTERYGIUM	68
37244	DOUBLE PTERYGIUM	68
37245	RECURRENT PTERYGIUM	68
37250	CONJUNCTIVAL DEGEN NOS	68
37251	PINGUECULA	68
37252	PSEUDOPTERYGIUM	68
37253	CONJUNCTIVAL XEROSIS	68
37254	CONJUNCTIVAL CONCRETIONS	68
37255	CONJUNCTIVA PIGMENTATION	68
37256	CONJUNCTIVAL DEPOSITS	68
37261	GRANULOMA OF CONJUNCTIVA	68
37262	LOCAL CONJUNCTIVA ADHES	68
37263	SYMBLEPHARON	68
37264	SCARRING OF CONJUNCTIVA	68
37271	HYPEREMIA OF CONJUNCTIVA	68
37272	CONJUNCTIVAL HEMORRHAGE	68
37273	CONJUNCTIVAL EDEMA	68
37274	CONJUNCTIVA VASC ANOMALY	68
37275	CONJUNCTIVAL CYSTS	68
3728	CONJUNCTIVA DISORDER NEC	68
3729	CONJUNCTIVA DISORDER NOS	68
37300	BLEPHARITIS NOS	68
37301	ULCERATIVE BLEPHARITIS	68
37302	SQUAMOUS BLEPHARITIS	68
37311	HORDEOLUM EXTERNUM	68
37312	HORDEOLUM INTERNUM	68
37313	ABSCESS OF EYELID	68
3732	CHALAZION	68
37331	ECZEM DERMATITIS EYELID	68
37332	CONTACT DERMATIT EYELID	68
37333	XERODERMA OF EYELID	68
37334	DISC LUP ERYTHEMATOS LID	68
3734	INFECT DERM LID W DEFORM	68
3735	INFEC DERMATITIS LID NEC	68
3736	PARASITIC INFEST EYELID	68
3738	INFLAMMATION EYELID NEC	68
3739	INFLAMMATION EYELID NOS	68
37400	ENTROPION NOS	68
37401	SENILE ENTROPION	68
37402	MECHANICAL ENTROPION	68
37403	SPASTIC ENTROPION	68
37404	CICATRICIAL ENTROPION	68
37405	TRICHIASIS W/O ENTROPION	68
37410	ECTROPION NOS	68
37411	SENILE ECTROPION	68
37412	MECHANICAL ECTROPION	68
37413	SPASTIC ECTROPION	68
37414	CICATRICIAL ECTROPION	68
37420	LAGOPHTHALMOS NOS	68
37421	PARALYTIC LAGOPHTHALMOS	68
37422	MECHANICAL LAGOPHTHALMOS	68
37423	CICATRICIAL LAGOPHTHALM	68
37430	PTOSIS OF EYELID NOS	68
37431	PARALYTIC PTOSIS	68
37432	MYOGENIC PTOSIS	68
37433	MECHANICAL PTOSIS	68
37434	BLEPHAROCHALASIS	68
37441	LID RETRACTION OR LAG	68
37443	ABNORM INNERVATION SYND	68

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
37444	SENSORY DISORDERS, LID	68
37445	SENSORMOTR DISOR LID NEC	68
37446	BLEPHAROPHIMOSIS	68
37450	DEGEN DISORDER NOS, LID	68
37451	XANTHELASMA	18
37452	HYPERPIGMENTATION LID	68
37453	HYPOPIGMENTATION LID	68
37454	HYPERTRICHOSIS OF EYELID	68
37455	HYPOTRICHOSIS OF EYELID	68
37456	DEGEN DIS EYELID NEC	68
37481	HEMORRHAGE OF EYELID	68
37482	EDEMA OF EYELID	68
37483	ELEPHANTIASIS OF EYELID	68
37484	CYSTS OF EYELIDS	68
37485	VASCULAR ANOMALY, EYELID	68
37486	OLD FOREIGN BODY, EYELID	68
37487	DERMATOCHALASIS	68
37489	DISORDERS OF EYELID NEC	68
3749	DISORDER OF EYELID NOS	68
37500	DACRYOADENITIS NOS	68
37501	ACUTE DACRYOADENITIS	68
37502	CHRONIC DACRYOADENITIS	68
37503	CH ENLARGMNT LACRIM GLND	68
37511	DACRYOPS	68
37512	LACRIMAL GLAND CYST NEC	68
37513	PRIMARY LACRIMAL ATROPHY	68
37514	SECONDARY LACRIM ATROPHY	68
37515	TEAR FILM INSUFFIC NOS	68
37516	LACRIMAL GLAND DISLOCAT	68
37520	EPIPHORA NOS	68
37521	EPIPHORA D/T EXCESS TEAR	68
37522	EPIPHORA D/T INSUF DRAIN	68
37530	DACRYOCYSTITIS NOS	68
37531	ACUTE CANALICULITIS	68
37532	ACUTE DACRYOCYSTITIS	68
37533	PHLEGMON DACRYOCYSTITIS	68
37541	CHRONIC CANALICULITIS	68
37542	CHRONIC DACRYOCYSTITIS	68
37543	LACRIMAL MUCOCELE	68
37551	LACRIML PUNCTUM EVERSION	68
37552	LACRIML PUNCTUM STENOSIS	68
37553	LACRIM CANALIC STENOSIS	68
37554	LACRIMAL SAC STENOSIS	68
37555	NEONATAL NASOLACRML OBST	68
37556	ACQ NASOLACRML STENOSIS	68
37557	DACRYOLITH	68
37561	LACRIMAL FISTULA	68
37569	LACRIM PASSGE CHANGE NEC	68
37581	LACRIM PASSAGE GRANULOMA	68
37589	LACRIMAL SYST DIS NEC	68
3759	LACRIMAL SYST DIS NOS	68
37600	ACUTE INFLAM NOS, ORBIT	68
37601	ORBITAL CELLULITIS	68
37602	ORBITAL PERIOSTITIS	68
37603	ORBITAL OSTEOMYELITIS	68
37604	ORBITAL TENONITIS	68
37610	CHR INFLAM NOS, ORBIT	68
37611	ORBITAL GRANULOMA	68
37612	ORBITAL MYOSITIS	68
37613	PARASITE INFEST, ORBIT	68
37621	THYROTOXIC EXOPHTHALMOS	68
37622	EXOPHTHALM OPHTHALMOPLEG	68
37630	EXOPHTHALMOS NOS	68
37631	CONSTANT EXOPHTHALMOS	68
37632	ORBITAL HEMORRHAGE	68
37633	ORBITAL EDEMA	68
37634	INTERMITTNT EXOPHTHALMOS	68
37635	PULSATING EXOPHTHALMOS	68
37636	LATERAL GLOBE DISPLACMNT	68
37640	DEFORMITY OF ORBIT NOS	68
37641	HYPERTELORISM OF ORBIT	68
37642	EXOSTOSIS OF ORBIT	68
37643	ORBT DEFORM D/T BONE DIS	68
37644	CRANIOFACIAL-ORBIT DEFOR	68
37645	ATROPHY OF ORBIT	68
37646	ENLARGEMENT OF ORBIT	68

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
37647	ORBIT DEFORM D/T TRAUMA	68
37650	ENOPHTHALMOS NOS	68
37651	ENOPHTH D/T ORBIT ATRPHY	68
37652	ENOPHTHALMOS D/T TRAUMA	68
3766	OLD FOREIGN BODY, ORBIT	68
37681	ORBITAL CYSTS	68
37682	EXTRAOCUL MUSCL MYOPATHY	68
37689	ORBITAL DISORDERS NEC	68
3769	ORBITAL DISORDER NOS	68
37700	PAPILLEDEMA NOS	68
37701	PAPILLEDEMA W INCR PRESS	68
37702	PAPILLEDEMA W DECR PRESS	68
37703	PAPILLEDEMA W RETINA DIS	68
37704	FOSTER-KENNEDY SYNDROME	63
37710	OPTIC ATROPHY NOS	63
37711	PRIMARY OPTIC ATROPHY	63
37712	POSTINFLAM OPTIC ATROPHY	63
37713	OPTIC ATRPH W RETIN DYST	63
37714	CUPPING OF OPTIC DISC	63
37715	PARTIAL OPTIC ATROPHY	63
37716	HEREDITARY OPTIC ATROPHY	63
37721	DRUSEN OF OPTIC DISC	68
37722	CRATER-LIKE HOLE OP DISC	68
37723	COLOBOMA OF OPTIC DISC	68
37724	PSEUDOPAPILLEDEMA	78
37730	OPTIC NEURITIS NOS	68
37731	OPTIC PAPILLITIS	68
37732	RETROBULBAR NEURITIS	68
37733	NUTRITION OPTC NEUROPTHY	68
37734	TOXIC OPTIC NEUROPATHY	68
37739	OPTIC NEURITIS NEC	68
37741	ISCHEMIC OPTIC NEUROPTHY	68
37742	OPTIC NERVE SHEATH HEMOR	68
37749	OPTIC NERVE DISORDER NEC	68
37751	OPT CHIASM W PITUIT DIS	63
37752	OPT CHIASM DIS/NEOPL NEC	63
37753	OPT CHIASM W VASCUL DIS	63
37754	OP CHIASM DIS W INFL DIS	63
37761	VIS PATH DIS W NEOPLASMS	63
37762	VIS PATH DIS W VASC DIS	63
37763	VIS PATH DIS W INFL DIS	63
37771	VIS CORTX DIS W NEOPLASM	63
37772	VIS CORTX DIS W VASC DIS	63
37773	VIS CORTEX DIS W INFLAM	63
37775	CORTICAL BLINDNESS	63
3779	OPTIC NERVE DISORDER NOS	63
37800	ESOTROPIA NOS	68
37801	MONOCULAR ESOTROPIA	68
37802	MONOC ESOTROP W A PATTRN	68
37803	MONOC ESOTROP W V PATTRN	68
37804	MONOC ESOTROP W X/Y PAT	68
37805	ALTERNATING ESOTROPIA	68
37806	ALT ESOTROPIA W A PATTRN	68
37807	ALT ESOTROPIA W V PATTRN	68
37808	ALT ESOTROP W X/Y PATTRN	68
37810	EXOTROPIA NOS	68
37811	MONOCULAR EXOTROPIA	68
37812	MONOC EXOTROP W A PATTRN	68
37813	MONOC EXOTROP W V PATTRN	68
37814	MONOC EXOTROP W X/Y PAT	68
37815	ALTERNATING EXOTROPIA	68
37816	ALT EXOTROPIA W A PATTRN	68
37817	ALT EXOTROPIA W V PATTRN	68
37818	ALT EXOTROP W X/Y PATTRN	68
37820	INTERMIT HETEROTROP NOS	68
37821	INTERMIT MONOC ESOTROPIA	68
37822	INTERMIT ALTRN ESOTROPIA	68
37823	INTERMIT MONOC EXOTROPIA	68
37824	INTERMIT ALTRN EXOTROPIA	68
37830	HETEROTROPIA NOS	68
37831	HYPERTROPIA	68
37832	HYPOTROPIA	68
37833	CYCLOTROPIA	68
37834	MONOFIXATION SYNDROME	68
37835	ACCOMMODATIVE ESOTROPIA	68
37840	HETEROPHORIA NOS	68

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
37841	ESOPHORIA	68
37842	EXOPHORIA	68
37843	VERTICAL HETEROPHORIA	68
37844	CYCLOPHORIA	68
37845	ALTERNATING HYPERPHORIA	68
37850	PARALYTIC STRABISMUS NOS	68
37851	PARTIAL THIRD NERV PALSY	68
37852	TOTAL THIRD NERVE PALSY	68
37853	FOURTH NERVE PALSY	68
37854	SIXTH NERVE PALSY	68
37855	EXTERNAL OPHTHALMOPLEGIA	68
37856	TOTAL OPHTHALMOPLEGIA	68
37860	MECHANICAL STRABISM NOS	68
37861	BROWN'S SHEATH SYNDROME	68
37862	MECH STRAB D/T MUSCL DIS	68
37863	MECH STRAB W OTH CONDITN	68
37871	DUANE'S SYNDROME	68
37872	PROG EXT OPHTHALMOPLEGIA	68
37873	NEUROMUSCLE DIS STRABISM	68
37881	PALSY OF CONJUGATE GAZE	68
37882	SPASM OF CONJUGATE GAZE	68
37883	CONVERGENC INSUFFICIENCY	68
37884	CONVERGENCE EXCESS	68
37885	ANOMALIES OF DIVERGENCE	68
37886	INTERNUCL OPHTHALMOPLEG	63
37887	SKEW DEVIATION, EYE	68
3789	EYE MOVEMNT DISORDER NOS	68
37900	SCLERITIS NOS	68
37901	EPISCLERIT PERIODIC FUGX	68
37902	NODULAR EPISCLERITIS	68
37903	ANTERIOR SCLERITIS	68
37904	SCLEROMALACIA PERFORANS	68
37905	SCLERITIS W CORNEA INVOL	68
37906	BRAWNY SCLERITIS	68
37907	POSTERIOR SCLERITIS	68
37909	SCLERITIS NEC	68
37911	SCLERAL ECTASIA	68
37912	STAPHYLOMA POSTICUM	68
37913	EQUATORIAL STAPHYLOMA	68
37914	LOCAL ANTERIOR STAPHYLMA	68
37915	RING STAPHYLOMA	68
37916	SCLERAL DEGEN DIS NEC	68
37919	DISORDER OF SCLERA NEC	68
37921	VITREOUS DEGENERATION	68
37922	CRYSTAL DEPOSIT VITREOUS	68
37923	VITREOUS HEMORRHAGE	68
37924	VITREOUS OPACITIES NEC	68
37925	VITREOUS MEMBRANES	68
37926	VITREOUS PROLAPSE	68
37929	VITREOUS DISORDERS NEC	68
37931	APHAKIA	68
37932	SUBLUXATION OF LENS	68
37933	ANT DISLOCATION OF LENS	68
37934	POST DISLOCATION OF LENS	68
37939	DISORDERS OF LENS NEC	68
37940	ABN PUPIL FUNCTION NOS	68
37941	ANISOCORIA	68
37942	MIOSIS NOT D/T MIOTICS	68
37943	MYDRIASIS NOT D/T MYDRTC	68
37945	ARGYLL ROBERTSON PUPIL	68
37946	TONIC PUPILLARY REACTION	68
37949	PUPIL FUNCT ANOMALY NEC	68
37950	NYSTAGMUS NOS	68
37951	CONGENITAL NYSTAGMUS	68
37952	LATENT NYSTAGMUS	68
37953	VISUAL DEPRIVATN NYSTAGM	68
37954	NYSTAGMS W VESTIBULR DIS	68
37955	DISSOCIATED NYSTAGMUS	68
37956	NYSTAGMUS NEC	68
37957	SACCADIC EYE MOVMNT DEF	68
37958	SMOOTH PURSUIT MVMNT DEF	68
37959	IRREGULAR EYE MVMNTS NEC	68
3798	EYE DISORDERS NEC	68
37990	EYE DISORDER NOS	68
37991	PAIN IN OR AROUND EYE	68
37992	SWELLING OR MASS OF EYE	68

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
37993	REDNESS/DISCHARGE OF EYE	68
37999	ILL-DEFINED EYE DIS NEC	68
38000	PERICHONDRITIS PINNA NOS	31
38001	AC PERICHONDRITIS PINNA	24
38002	CHR PERICHONDRITIS PINNA	24
38010	INFEC OTITIS EXTERNA NOS	31
38011	ACUTE INFECTION OF PINNA	31
38012	ACUTE SWIMMERS' EAR	31
38013	AC INFECT EXTERN EAR NEC	31
38014	MALIGNANT OTITIS EXTERNA	31
38015	CHR MYCOT OTITIS EXTERNA	31
38016	CHR INF OTIT EXTERNA NEC	31
38021	CHOLESTEATOMA EXTERN EAR	31
38022	ACUTE OTITIS EXTERNA NEC	31
38023	CHR OTITIS EXTERNA NEC	31
38030	DISORDER OF PINNA NOS	31
38031	HEMATOMA AURICLE/PINNA	31
38032	ACQ DEFORM AURICLE/PINNA	31
38039	NONINFECT DIS PINNA NEC	31
3804	IMPACTED CERUMEN	31
38050	ACQ STENOS EAR CANAL NOS	31
38051	STENOSIS EAR D/T TRAUMA	31
38052	STENOSIS EAR D/T SURGERY	31
38053	STENOSIS EAR D/T INFLAM	31
38081	EXOSTOSIS EXT EAR CANAL	31
38089	DIS EXTERNAL EAR NEC	31
3809	DIS EXTERNAL EAR NOS	31
38100	AC NONSUP OTITIS MED NOS	31
38101	AC SEROUS OTITIS MEDIA	31
38102	AC MUCOID OTITIS MEDIA	31
38103	AC SANGUIN OTITIS MEDIA	31
38104	AC ALLERGIC SEROUS OM	31
38105	AC ALLERGIC MUCOID OM	31
38106	AC ALLERG SANGUINOUS OM	31
38110	CHR SEROUS OM SIMP/NOS	31
38119	CHR SEROUS OM NEC	31
38120	CHR MUCOID OM SIMP/NOS	31
38129	CHR MUCOID OM NEC	31
3813	CHR NONSUP OM NOS/NEC	31
3814	NONSUPP OTITIS MEDIA NOS	31
38150	EUSTACHIAN SALPING NOS	31
38151	AC EUSTACHIAN SALPING	31
38152	CHR EUSTACHIAN SALPING	31
38160	OBSTR EUSTACH TUBE NOS	31
38161	OSSEOUS EUSTACHIAN OBSTR	31
38162	INTRINSIC EUSTACH OBSTR	31
38163	EXTRINSIC EUSTACH OBSTR	31
3817	PATULOUS EUSTACHIAN TUBE	31
38181	DYSFUNCT EUSTACHIAN TUBE	31
38189	EUSTACHIAN TUBE DIS NEC	31
3819	EUSTACHIAN TUBE DIS NOS	31
38200	AC SUPP OTITIS MEDIA NOS	31
38201	AC SUPP OM W DRUM RUPT	31
38202	AC SUPP OM IN OTH DIS	31
3821	CHR TUBOTYMPAN SUPPUR OM	31
3822	CHR ATTICOANTRAL SUP OM	31
3823	CHR SUP OTITIS MEDIA NOS	31
3824	SUPPUR OTITIS MEDIA NOS	31
3829	OTITIS MEDIA NOS	31
38300	AC MASTOIDITIS W/O COMPL	31
38301	SUBPERI MASTOID ABSCESS	31
38302	AC MASTOIDITIS-COMPL NEC	31
3831	CHRONIC MASTOIDITIS	31
38320	PETROSITIS NOS	31
38321	ACUTE PETROSITIS	31
38322	CHRONIC PETROSITIS	31
38330	POSTMASTOID COMPL NOS	31
38331	POSTMASTOID MUCOSAL CYST	31
38332	POSTMASTOID CHOLESTEATMA	31
38333	POSTMASTOID GRANULATIONS	31
38381	POSTAURICULAR FISTULA	31
38389	DISORDERS OF MASTOID NEC	31
3839	MASTOIDITIS NOS	31
38400	ACUTE MYRINGITIS NOS	31
38401	BULLOUS MYRINGITIS	31
38409	ACUTE MYRINGITIS NEC	31

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
3841	CHRONIC MYRINGITIS	31
38420	PERFORAT TYMPAN MEMB NOS	31
38421	CENT PERF TYMPANIC MEMB	31
38422	ATTIC PERF TYMPANIC MEMB	31
38423	MARGINAL PERF TYMP NEC	31
38424	MULT PERF TYMPANIC MEMB	31
38425	TOTAL PERF TYMPANIC MEMB	31
38481	ATROPHIC FLACCID TYMPAN	31
38482	ATROPHIC NONFLACCID TYMP	31
3849	DIS TYMPANIC MEMB NOS	31
38500	TYMPANOSCLEROSIS NOS	31
38501	TYMPANOSCL-TYMPANIC MEMB	31
38502	TYMPNOSCLER-TYMP/OSSICLE	31
38503	TYMPANOSCLER-ALL PARTS	31
38509	TYMPNSCLR-OTH SITE COMB	31
38510	ADHESIVE MID EAR DIS NOS	31
38511	ADHESION TYMPANUM-INCUS	31
38512	ADHESION TYMPANUM-STAPES	31
38513	ADHESION TYMP-PROMONTOR	31
38519	ADHESIVE MID EAR DIS NEC	31
38521	ANKYLOSIS MALLEUS	31
38522	ANKYLOSIS EAR OSSICL NEC	31
38523	DISLOCATION EAR OSSICLE	31
38524	PARTIAL LOSS EAR OSSICLE	31
38530	CHOLESTEATOMA NOS	31
38531	CHOLESTEATOMA OF ATTIC	31
38532	CHOLESTEATOMA MIDDLE EAR	31
38533	CHOLESTMA MID EAR/MSTOID	31
38535	DIFFUSE CHOLESTEATOSIS	31
38582	CHOLESTERIN GRANULOMA	31
38583	FOREIGN BODY MIDDLE EAR	31
38589	DIS MID EAR/MASTOID NEC	31
3859	DIS MID EAR/MASTOID NOS	31
38600	MENIERE'S DISEASE NOS	31
38601	MENIERE DIS COCHLVESTIB	31
38602	MENIERE DIS COCHLEAR	31
38603	MENIERE DIS VESTIBULAR	31
38604	INACTIVE MENIERE'S DIS	31
38610	PERIPHERAL VERTIGO NOS	31
38611	BENIGN PARXYSMAL VERTIGO	31
38612	VESTIBULAR NEURONITIS	31
38619	PERIPHERAL VERTIGO NEC	31
3862	CENTRAL ORIGIN VERTIGO	31
38630	LABYRINTHITIS NOS	31
38631	SEROUS LABYRINTHITIS	31
38632	CIRCUMSCRI LABYRINTHITIS	31
38633	SUPPURATIV LABYRINTHITIS	31
38634	TOXIC LABYRINTHITIS	31
38635	VIRAL LABYRINTHITIS	31
38640	LABYRINTHINE FISTULA NOS	31
38641	ROUND WINDOW FISTULA	31
38642	OVAL WINDOW FISTULA	31
38643	SEMICIRCUL CANAL FISTULA	31
38648	LABYRINTH FISTULA COMB	31
38650	LABYRINTHINE DYSFUNC NOS	31
38651	HYPRACT LABYRINTH UNILAT	31
38652	HYPERACT LABYRINTH BILAT	31
38653	HYPOACT LABYRINTH UNILAT	31
38654	HYPOACT LABYRINTH BILAT	31
38655	LOSS LABYRN REACT UNILAT	31
38656	LOSS LABYRIN REACT BILAT	31
38658	LABYRINTHINE DYSFUNC NEC	31
3868	DISORDERS LABYRINTH NEC	31
3869	VERTIGINOUS SYND NOS	31
3870	OTOSCLER-OVAL WND NONOBL	31
3871	OTOSCLER-OVAL WNDW OBLIT	31
3872	COCHLEAR OTOSCLEROSIS	31
3878	OTOSCLEROSIS NEC	31
3879	OTOSCLEROSIS NOS	31
38800	DEGEN/VASCUL DIS EAR NOS	31
38801	PRESBYACUSIS	31
38802	TRANS ISCHEMIC DEAFNESS	31
38810	NOISE EFFECT-EAR/NOS	31
38811	ACOUSTIC TRAUMA	31
38812	HEARING LOSS D/T NOISE	31
3882	SUDDEN HEARING LOSS NOS	31

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
38830	TINNITUS NOS	31
38831	SUBJECTIVE TINNITUS	31
38832	OBJECTIVE TINNITUS	31
38840	ABN AUDITORY PERCEPT NOS	31
38841	DIPLACUSIS	31
38842	HYPERACUSIS	31
38843	IMPAIRM AUDITORY DISCRIM	31
38844	AUDITORY RECRUITMENT	31
3885	ACOUSTIC NERVE DISORDERS	31
38860	OTORRHEA NOS	31
38861	CEREBROSP FLUID OTORRHEA	63
38869	OTORRHEA NEC	31
38870	OTALGIA NOS	31
38871	OTOGENIC PAIN	31
38872	REFERRED PAIN OF EAR	31
3888	DISORDERS OF EAR NEC	31
3889	DISORDER OF EAR NOS	31
38900	CONDUCT HEARING LOSS NOS	31
38901	CONDUC HEAR LOSS EXT EAR	31
38902	CONDUCT HEAR LOSS TYMPAN	31
38903	CONDUC HEAR LOSS MID EAR	31
38904	COND HEAR LOSS INNER EAR	31
38908	COND HEAR LOSS COMB TYPE	31
38910	SENSORNEUR HEAR LOSS NOS	31
38911	SENSORY HEARING LOSS	31
38912	NEURAL HEARING LOSS	31
38914	CENTRAL HEARING LOSS	31
38918	SENSORNEUR LOSS COMB TYP	31
3892	MIXED HEARING LOSS	31
3897	DEAF MUTISM NEC	31
3898	HEARING LOSS NEC	31
3899	HEARING LOSS NOS	31
390	RHEUM FEV W/O HRT INVOLV	24
3910	ACUTE RHEUMATIC PERICARD	36
3911	ACUTE RHEUMATIC ENDOCARD	36
3912	AC RHEUMATIC MYOCARDITIS	36
3918	AC RHEUMAT HRT DIS NEC	36
3919	AC RHEUMAT HRT DIS NOS	36
3920	RHEUM CHOREA W HRT INVOL	36
3929	RHEUMATIC CHOREA NOS	36
393	CHR RHEUMATIC PERICARD	36
3940	MITRAL STENOSIS	36
3941	RHEUMATIC MITRAL INSUFF	36
3942	MITRAL STENOSIS W INSUFF	36
3949	MITRAL VALVE DIS NEC/NOS	36
3950	RHEUMAT AORTIC STENOSIS	36
3951	RHEUMATIC AORTIC INSUFF	36
3952	RHEUM AORTIC STEN/INSUFF	36
3959	RHEUM AORTIC DIS NEC/NOS	36
3960	MITRAL/AORTIC STENOSIS	36
3961	MITRAL STENOS/AORT INSUF	36
3962	MITRAL INSUF/AORT STENOS	36
3963	MITRAL/AORTIC VAL INSUFF	36
3968	MITR/AORTIC MULT INVOLV	36
3969	MITRAL/AORTIC V DIS NOS	36
3970	TRICUSPID VALVE DISEASE	36
3971	RHEUM PULMON VALVE DIS	36
3979	RHEUM ENDOCARDITIS NOS	36
3980	RHEUMATIC MYOCARDITIS	36
39890	RHEUMATIC HEART DIS NOS	36
39891	RHEUMATIC HEART FAILURE	36
39899	RHEUMATIC HEART DIS NEC	36
4010	MALIGNANT HYPERTENSION	36
4011	BENIGN HYPERTENSION	36
4019	HYPERTENSION NOS	36
40200	MAL HYPERTEN HRT DIS NOS	36
40201	MAL HYPERT HRT DIS W CHF	36
40210	BEN HYPERTEN HRT DIS NOS	36
40211	BENIGN HYP HRT DIS W CHF	36
40290	HYPERTENSIVE HRT DIS NOS	36
40291	HYPERTEN HEART DIS W CHF	36
40300	MAL HYP REN W/O REN FAIL	36
40301	MAL HYP REN W RENAL FAIL	53
40310	BEN HYP REN W/O REN FAIL	36
40311	BEN HYP RENAL W REN FAIL	53
40390	HYP REN NOS W/O REN FAIL	36

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
40391	HYP RENAL NOS W REN FAIL	53
40400	MAL HY HT/REN W/O CHF/RF	36
40401	MAL HYPER HRT/REN W CHF	36
40402	MAL HY HT/REN W REN FAIL	53
40403	MAL HYP HRT/REN W CHF&RF	36
40410	BEN HY HT/REN W/O CHF/RF	36
40411	BEN HYPER HRT/REN W CHF	36
40412	BEN HY HT/REN W REN FAIL	53
40413	BEN HYP HRT/REN W CHF&RF	36
40490	HY HT/REN NOS W/O CHF/RF	36
40491	HYPER HRT/REN NOS W CHF	36
40492	HY HT/REN NOS W REN FAIL	53
40493	HYP HT/REN NOS W CHF&RF	36
40501	MAL RENOVASC HYPERTENS	36
40509	MAL SECOND HYPERTEN NEC	36
40511	BENIGN RENOVASC HYPERTEN	36
40519	BENIGN SECOND HYPERT NEC	36
40591	RENOVASC HYPERTENSION	36
40599	SECOND HYPERTENSION NEC	36
41000	AMI ANTEROLATERAL, UNSPEC	36
41001	AMI ANTEROLATERAL, INIT	36
41002	AMI ANTEROLATERAL, SUBSEQ	36
41010	AMI ANTERIOR WALL, UNSPEC	36
41011	AMI ANTERIOR WALL, INIT	36
41012	AMI ANTERIOR WALL, SUBSEQ	36
41020	AMI INFEROLATERAL, UNSPEC	36
41021	AMI INFEROLATERAL, INIT	36
41022	AMI INFEROLATERAL, SUBSEQ	36
41030	AMI INFEROPOST, UNSPEC	36
41031	AMI INFEROPOST, INITIAL	36
41032	AMI INFEROPOST, SUBSEQ	36
41040	AMI INFERIOR WALL, UNSPEC	36
41041	AMI INFERIOR WALL, INIT	36
41042	AMI INFERIOR WALL, SUBSEQ	36
41050	AMI LATERAL NEC, UNSPEC	36
41051	AMI LATERAL NEC, INITIAL	36
41052	AMI LATERAL NEC, SUBSEQ	36
41060	TRUE POST INFARCT, UNSPEC	36
41061	TRUE POST INFARCT, INIT	36
41062	TRUE POST INFARCT, SUBSEQ	36
41070	SUBENDO INFARCT, UNSPEC	36
41071	SUBENDO INFARCT, INITIAL	36
41072	SUBENDO INFARCT, SUBSEQ	36
41080	AMI NEC, UNSPECIFIED	36
41081	AMI NEC, INITIAL	36
41082	AMI NEC, SUBSEQUENT	36
41090	AMI NOS, UNSPECIFIED	36
41091	AMI NOS, INITIAL	36
41092	AMI NOS, SUBSEQUENT	36
4110	POST MI SYNDROME	36
4111	INTERMED CORONARY SYND	36
41181	CORONARY OCCLSN W/O MI	36
41189	AC ISCHEMIC HRT DIS NEC	36
412	OLD MYOCARDIAL INFARCT	36
4130	ANGINA DECUBITUS	36
4131	PRINZMETAL ANGINA	36
4139	ANGINA PECTORIS NEC/NOS	36
41400	COR ATH UNSP VSL NTV/GFT	36
41401	CRNRY ATHRSCL NATVE VSSL	36
41402	CRN ATH ATLG VN BPS GRFT	36
41403	CRN ATH NONATLG BLG GRFT	36
41410	ANEURYSM, HEART (WALL)	36
41411	CORONARY VESSEL ANEURYSM	36
41419	ANEURYSM OF HEART NEC	36
4148	CHR ISCHEMIC HRT DIS NEC	36
4149	CHR ISCHEMIC HRT DIS NOS	36
4150	ACUTE COR PULMONALE	36
41511	IATROGEN PULM EMB/INFARC	33
41519	PULM EMBOL/INFARCT NEC	33
4160	PRIM PULM HYPERTENSION	36
4161	KYPHOSCOLIOTIC HEART DIS	36
4168	CHR PULMON HEART DIS NEC	36
4169	CHR PULMON HEART DIS NOS	36
4170	ARTERIOVEN FISTU PUL VES	36
4171	PULMON ARTERY ANEURYSM	36
4178	PULMON CIRCULAT DIS NEC	36

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
4179	PULMON CIRCULAT DIS NOS	36
4200	AC PERICARDIT IN OTH DIS	36
42090	ACUTE PERICARDITIS NOS	36
42091	AC IDIOPATH PERICARDITIS	36
42099	ACUTE PERICARDITIS NEC	36
4210	AC/SUBAC BACT ENDOCARD	36
4211	AC ENDOCARDIT IN OTH DIS	36
4219	AC/SUBAC ENDOCARDIT NOS	36
4220	AC MYOCARDIT IN OTH DIS	36
42290	ACUTE MYOCARDITIS NOS	36
42291	IDIOPATHIC MYOCARDITIS	36
42292	SEPTIC MYOCARDITIS	36
42293	TOXIC MYOCARDITIS	36
42299	ACUTE MYOCARDITIS NEC	36
4230	HEMOPERICARDIUM	36
4231	ADHESIVE PERICARDITIS	36
4232	CONSTRICTIV PERICARDITIS	36
4238	PERICARDIAL DISEASE NEC	36
4239	PERICARDIAL DISEASE NOS	36
4240	MITRAL VALVE DISORDER	36
4241	AORTIC VALVE DISORDER	36
4242	NONRHEUM TRICUSP VAL DIS	36
4243	PULMONARY VALVE DISORDER	36
42490	ENDOCARDITIS NOS	36
42491	ENDOCARDITIS IN OTH DIS	36
42499	ENDOCARDITIS NEC	36
4250	ENDOMYOCARDIAL FIBROSIS	36
4251	HYPERTR OBSTR CARDIOMYOP	36
4252	OBSC AFRIC CARDIOMYOPATH	36
4253	ENDOCARD FIBROELASTOSIS	36
4254	PRIM CARDIOMYOPATHY NEC	36
4255	ALCOHOLIC CARDIOMYOPATHY	36
4257	METABOLIC CARDIOMYOPATHY	36
4258	CARDIOMYOPATH IN OTH DIS	36
4259	SECOND CARDIOMYOPATH NOS	36
4260	ATRIOVENT BLOCK COMPLETE	36
42610	ATRIOVENT BLOCK NOS	36
42611	ATRIOVENT BLOCK-1ST DEGR	36
42612	ATRIOVEN BLOCK-MOBITZ II	36
42613	AV BLOCK-2ND DEGREE NEC	36
4262	LEFT BB HEMIBLOCK	36
4263	LEFT BB BLOCK NEC	36
4264	RT BUNDLE BRANCH BLOCK	36
42650	BUNDLE BRANCH BLOCK NOS	36
42651	RT BBB/LFT POST FASC BLK	36
42652	RT BBB/LFT ANT FASC BLK	36
42653	BILAT BB BLOCK NEC	36
42654	TRIFASCICULAR BLOCK	36
4266	OTHER HEART BLOCK	36
4267	ANOMALOUS AV EXCITATION	36
42681	LOWN-GANONG-LEVINE SYND	36
42689	CONDUCTION DISORDER NEC	36
4269	CONDUCTION DISORDER NOS	36
4270	PAROX ATRIAL TACHYCARDIA	36
4271	PAROX VENTRIC TACHYCARD	78
4272	PAROX TACHYCARDIA NOS	36
42731	ATRIAL FIBRILLATION	36
42732	ATRIAL FLUTTER	36
42741	VENTRICULAR FIBRILLATION	78
42742	VENTRICULAR FLUTTER	78
4275	CARDIAC ARREST	78
42760	PREMATURE BEATS NOS	36
42761	ATRIAL PREMATURE BEATS	36
42769	PREMATURE BEATS NEC	36
42781	SINOATRIAL NODE DYSFUNCT	36
42789	CARDIAC DYSRHYTHMIAS NEC	36
4279	CARDIAC DYSRHYTHMIA NOS	36
4280	CONGESTIVE HEART FAILURE	36
4281	LEFT HEART FAILURE	36
4289	HEART FAILURE NOS	36
4290	MYOCARDITIS NOS	36
4291	MYOCARDIAL DEGENERATION	36
4292	ASCVD	36
4293	CARDIOMEGALY	36
4294	HRT DIS POSTCARDIAC SURG	36
4295	CHORDAE TENDINAE RUPTURE	36

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
4296	PAPILLARY MUSCLE RUPTURE	36
42971	ACQ CARDIAC SEPTL DEFECT	36
42979	OTHER SEQUELAE OF MI NEC	36
42981	PAPILLARY MUSCLE DIS NEC	36
42982	HYPERKINETIC HEART DIS	36
42989	ILL-DEFINED HRT DIS NEC	36
4299	HEART DISEASE NOS	36
430	SUBARACHNOID HEMORRHAGE	63
431	INTRACEREBRAL HEMORRHAGE	63
4320	NONTRAUM EXTRADURAL HEM	63
4321	SUBDURAL HEMORRHAGE	63
4329	INTRACRANIAL HEMORR NOS	63
43300	OCL BSLR ART WO INFRCT	63
43301	OCL BSLR ART W INFRCT	63
43310	OCL CRTD ART WO INFRCT	63
43311	OCL CRTD ART W INFRCT	63
43320	OCL VRTB ART WO INFRCT	63
43321	OCL VRTB ART W INFRCT	63
43330	OCL MLT BI ART WO INFRCT	63
43331	OCL MLT BI ART W INFRCT	63
43380	OCL SPCF ART WO INFRCT	63
43381	OCL SPCF ART W INFRCT	63
43390	OCL ART NOS WO INFRCT	63
43391	OCL ART NOS W INFRCT	63
43400	CRBL THRMBS WO INFRCT	63
43401	CRBL THRMBS W INFRCT	63
43410	CRBL EMBLSM WO INFRCT	63
43411	CRBL EMBLSM W INFRCT	63
43490	CRBL ART OC NOS WO INFRC	63
43491	CRBL ART OCL NOS W INFRC	63
4350	BASILAR ARTERY SYNDROME	63
4351	VERTEBRAL ARTERY SYNDROM	63
4352	SUBCLAVIAN STEAL SYNDROM	63
4353	VERTBROBASLR ARTERY SYND	63
4358	TRANS CEREB ISCHEMIA NEC	63
4359	TRANS CEREB ISCHEMIA NOS	63
436	CVA	63
4370	CEREBRAL ATHEROSCLEROSIS	63
4371	AC CEREBROVASC INSUF NOS	63
4372	HYPERTENS ENCEPHALOPATHY	63
4373	NONRUPT CEREBRAL ANEURYM	63
4374	CEREBRAL ARTERITIS	63
4375	MOYAMOYA DISEASE	63
4376	NONPYOGEN THROMBOS SINUS	63
4377	TRANSIENT GLOBAL AMNESIA	11
4378	CEREBROVASC DISEASE NEC	63
4379	CEREBROVASC DISEASE NOS	63
4400	AORTIC ATHEROSCLEROSIS	36
4401	RENAL ARTERY ATHEROSCLER	53
44020	ATHSCL EXTRM NTV ART NOS	36
44021	ATH EXT NTV AT W CLAUDCT	36
44022	ATH EXT NTV AT W RST PN	36
44023	ATH EXT NTV ART ULCRTION	36
44024	ATH EXT NTV ART GNGRENE	36
44029	ATHRSC EXTRM NTV ART OTH	36
44030	ATHSCL EXTRM BPS GFT NOS	36
44031	ATH EXT AUTOLOGS BPS GFT	36
44032	ATH EXT NONAUTLG BPS GFT	36
4408	ATHEROSCLEROSIS NEC	36
4409	ATHEROSCLEROSIS NOS	36
44100	DSCT OF AORTA UNSP SITE	78
44101	DSCT OF THORACIC AORTA	78
44102	DSCT OF ABDOMINAL AORTA	78
44103	DSCT OF THORACOABD AORTA	78
4411	RUPTUR THORACIC ANEURYSM	78
4412	THORACIC AORTIC ANEURYSM	36
4413	RUPT ABD AORTIC ANEURYSM	78
4414	ABDOM AORTIC ANEURYSM	36
4415	RUPT AORTIC ANEURYSM NOS	78
4416	THORACOABD ANEURYSM RUPT	78
4417	THRACABD ANURYSM WO RUPT	36
4419	AORTIC ANEURYSM NOS	36
4420	UPPER EXTREMITY ANEURYSM	36
4421	RENAL ARTERY ANEURYSM	53
4422	ILIAC ARTERY ANEURYSM	36
4423	LOWER EXTREMITY ANEURYSM	36

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
44281	ANEURYSM OF NECK	36
44282	SUBCLAVIAN ANEURYSM	36
44283	SPLENIC ARTERY ANEURYSM	36
44284	VISCERAL ANEURYSM NEC	36
44289	ANEURYSM NEC	36
4429	ANEURYSM NOS	36
4430	RAYNAUD'S SYNDROME	86
4431	THROMBOANGIIT OBLITERANS	36
44381	ANGIOPATHY IN OTHER DIS	36
44389	PERIPH VASCULAR DIS NEC	36
4439	PERIPH VASCULAR DIS NOS	36
4440	ABD AORTIC EMBOLISM	36
4441	THORACIC AORTIC EMBOLISM	36
44421	UPPER EXTREMITY EMBOLISM	36
44422	LOWER EXTREMITY EMBOLISM	36
44481	ILIAC ARTERY EMBOLISM	36
44489	ARTERIAL EMBOLISM NEC	36
4449	ARTERIAL EMBOLISM NOS	36
4460	POLYARTERITIS NODOSA	86
4461	MUCOCUTAN LYMPH NODE SYN	86
4462	HYPERSENSITIV ANGIITIS*	86
44620	HYPERSENSIT ANGIITIS NOS	86
44621	GOODPASTURE'S SYNDROME	86
44629	HYPERSENSIT ANGIITIS NEC	86
4463	LETHAL MIDLINE GRANULOMA	86
4464	WEGENER'S GRANULOMATOSIS	86
4465	GIANT CELL ARTERITIS	86
4466	THROMBOT MICROANGIOPATHY	86
4467	TAKAYASU'S DISEASE	86
4470	ACQ ARTERIOVEN FISTULA	36
4471	STRICTURE OF ARTERY	36
4472	RUPTURE OF ARTERY	78
4473	RENAL ARTERY HYPERPLASIA	53
4474	CELIAC ART COMPRESS SYN	41
4475	NECROSIS OF ARTERY	36
4476	ARTERITIS NOS	24
4478	ARTERIAL DISEASE NEC	36
4479	ARTERIAL DISEASE NOS	36
4480	HEREDIT HEMORR TELANGIEC	36
4481	NEVUS, NON-NEOPLASTIC	18
4489	CAPILLARY DIS NEC/NOS	36
4510	SUPERFIC PHLEBITIS-LEG	36
45111	FEMORAL VEIN PHLEBITIS	36
45119	DEEP PHLEBITIS-LEG NEC	36
4512	THROMBOPHLEBITIS LEG NOS	36
45181	ILIAC THROMBOPHLEBITIS	36
45182	PHLBTS SPRFC VN UP EXTRM	36
45183	PHLBTS DEEP VN UP EXTRM	36
45184	PHLBTS VN NOS UP EXTRM	36
45189	THROMBOPHLEBITIS NEC	36
4519	THROMBOPHLEBITIS NOS	36
452	PORTAL VEIN THROMBOSIS	41
4530	BUDD-CHIARI SYNDROME	41
4531	THROMBOPHLEBITIS MIGRANS	36
4532	VENA CAVA THROMBOSIS	36
4533	RENAL VEIN THROMBOSIS	53
4538	VENOUS THROMBOSIS NEC	36
4539	VENOUS THROMBOSIS NOS	36
4540	LEG VARICOSITY W ULCER	36
4541	LEG VARICOSITY W INFLAM	36
4542	VARICOS LEG ULCER/INFLAM	36
4549	VARICOSE VEIN OF LEG NOS	36
4550	INT HEMORRHOID W/O COMPL	41
4551	INT THROMBOS HEMORRHOID	41
4552	INT HEMRRHOID W COMP NEC	41
4553	EXT HEMORRHOID W/O COMPL	41
4554	EXT THROMBOS HEMORRHOID	41
4555	EXT HEMRRHOID W COMP NEC	41
4556	HEMORRHOIDS NOS	41
4557	THROMBOS HEMORRHOIDS NOS	41
4558	HEMRRHOID NOS W COMP NEC	41
4559	RESIDUAL HEMORRHOID TAGS	41
4560	ESOPHAG VARICES W BLEED	41
4561	ESOPH VARICES W/O BLEED	41
45620	BLEED ESOPH VAR OTH DIS	41
45621	ESOPH VARICE OTH DIS NOS	41

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
4563	SUBLINGUAL VARICES	36
4564	SCROTAL VARICES	53
4565	PELVIC VARICES	53
4566	VULVAL VARICES	56
4568	VARICES OF OTHER SITES	36
4570	POSTMASTECT LYMPHEDEMA	18
4571	OTHER LYMPHEDEMA	18
4572	LYMPHANGITIS	18
4578	NONINFECT LYMPH DIS NEC	86
4579	NONINFECT LYMPH DIS NOS	86
4580	ORTHOSTATIC HYPOTENSION	36
4581	CHRONIC HYPOTENSION	36
4582	IATROGENIC HYPOTENSION	82
4589	HYPOTENSION NOS	36
4590	HEMORRHAGE NOS	11
4591	POSTPHLEBITIC SYNDROME	36
4592	COMPRESSION OF VEIN	36
45981	VENOUS INSUFFICIENCY NOS	36
45989	CIRCULATORY DISEASE NEC	36
4599	CIRCULATORY DISEASE NOS	36
460	ACUTE NASOPHARYNGITIS	31
4610	AC MAXILLARY SINUSITIS	31
4611	AC FRONTAL SINUSITIS	31
4612	AC ETHMOIDAL SINUSITIS	31
4613	AC SPHENOIDAL SINUSITIS	31
4618	OTHER ACUTE SINUSITIS	31
4619	ACUTE SINUSITIS NOS	31
462	ACUTE PHARYNGITIS	31
463	ACUTE TONSILLITIS	31
4640	ACUTE LARYNGITIS	31
46410	AC TRACHEITIS NO OBSTRUC	31
46411	AC TRACHEITIS W OBSTRUCT	31
46420	AC LARYNGOTRACH NO OBSTR	31
46421	AC LARYNGOTRACH W OBSTR	31
46430	AC EPIGLOTTITIS NO OBSTR	31
46431	AC EPIGLOTTITIS W OBSTR	78
4644	CROUP	31
4650	ACUTE LARYNGOPHARYNGITIS	31
4658	ACUTE URI MULT SITES NEC	31
4659	ACUTE URI NOS	31
4660	ACUTE BRONCHITIS	33
470	DEVIATED NASAL SEPTUM	31
4710	POLYP OF NASAL CAVITY	31
4711	POLYPOID SINUS DEGEN	31
4718	NASAL SINUS POLYP NEC	31
4719	NASAL POLYP NOS	31
4720	CHRONIC RHINITIS	31
4721	CHRONIC PHARYNGITIS	31
4722	CHRONIC NASOPHARYNGITIS	31
4730	CHR MAXILLARY SINUSITIS	31
4731	CHR FRONTAL SINUSITIS	31
4732	CHR ETHMOIDAL SINUSITIS	31
4733	CHR SPHENOIDAL SINUSITIS	31
4738	CHRONIC SINUSITIS NEC	31
4739	CHRONIC SINUSITIS NOS	31
4740	CHRONIC TONSILLITIS*	31
47410	HYPERTROPHY T AND A	31
47411	HYPERTROPHY TONSILS	31
47412	HYPERTROPHY ADENOIDS	31
4742	ADENOID VEGETATIONS	31
4748	CHR T & A DIS NEC	31
4749	CHR T & A DIS NOS	31
475	PERITONSILLAR ABSCESS	31
4760	CHRONIC LARYNGITIS	31
4761	CHR LARYNGOTRACHEITIS	31
4770	RHINITIS DUE TO POLLEN	31
4778	ALLERGIC RHINITIS NEC	31
4779	ALLERGIC RHINITIS NOS	31
4780	HYPERTRPH NASAL TURBINAT	31
4781	NASAL & SINUS DIS NEC	31
47820	DISEASE OF PHARYNX NOS	31
47821	CELLULITIS OF PHARYNX	31
47822	PARAPHARYNGEAL ABSCESS	31
47824	RETROPHARYNGEAL ABSCESS	31
47825	EDEMA PHARYNX/NASOPHARYX	31
47826	CYST PHARYNX/NASOPHARYNX	31

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
47829	DISEASE OF PHARYNX NEC	31
47830	VOCAL CORD PARALYSIS NOS	31
47831	VOCAL PARAL UNILAT PART	31
47832	VOCAL PARAL UNILAT TOTAL	31
47833	VOCAL PARAL BILAT PART	31
47834	VOCAL PARAL BILAT TOTAL	31
4784	VOCAL CORD/LARYNX POLYP	31
4785	VOCAL CORD DISEASE NEC	31
4786	EDEMA OF LARYNX	31
47870	DISEASE OF LARYNX NOS	31
47871	LARYNGEAL CELLULITIS	31
47874	STENOSIS OF LARYNX	31
47875	LARYNGEAL SPASM	31
47879	DISEASE OF LARYNX NEC	31
4788	URT HYPERSENS REACT NOS	31
4789	UPPER RESP DIS NEC/NOS	31
4800	ADENOVIRAL PNEUMONIA	33
4801	RESP SYNCYT VIRAL PNEUM	33
4802	PARINFLUENZA VIRAL PNEUM	33
4808	VIRAL PNEUMONIA NEC	33
4809	VIRAL PNEUMONIA NOS	33
481	PNEUMOCOCCAL PNEUMONIA	33
4820	K. PNEUMONIAE PNEUMONIA	33
4821	PSEUDOMONAL PNEUMONIA	33
4822	H. INFLUENZAE PNEUMONIA	33
48230	STREPTOCOCCAL PNEUMN NOS	33
48231	PNEUMONIA STRPTOCOCCUS A	33
48232	PNEUMONIA STRPTOCOCCUS B	33
48239	PNEUMONIA OTH STREP	33
4824	STAPHYLOCOCCAL PNEUMONIA	33
48281	PNEUMONIA ANAEROBES	33
48282	PNEUMONIA E COLI	33
48283	PNEUMO OTH GRM-NEG BACT	33
48289	PNEUMONIA OTH SPCF BACT	33
4829	BACTERIAL PNEUMONIA NOS	33
4830	PNEU MYCPLSM PNEUMONIAE	33
4838	PNEUMON OTH SPEC ORGNSM	33
4841	PNEUM W CYTOMEG INCL DIS	33
4843	PNEUMONIA IN WHOOP COUGH	33
4845	PNEUMONIA IN ANTHRAX	33
4846	PNEUM IN ASPERGILLOSIS	33
4847	PNEUM IN OTH SYS MYCOSES	33
4848	PNEUM IN INFECT DIS NEC	33
485	BRONCHOPNEUMONIA ORG NOS	33
486	PNEUMONIA, ORGANISM NOS	33
4870	INFLUENZA WITH PNEUMONIA	33
4871	FLU W RESP MANIFEST NEC	31
4878	FLU W MANIFESTATION NEC	31
490	BRONCHITIS NOS	33
4910	SIMPLE CHR BRONCHITIS	33
4911	MUCOPURUL CHR BRONCHITIS	33
4912	OBSTRUCT CHR BRONCHITIS*	33
49120	OBS CHR BRNC W/O ACT EXA	33
49121	OBS CHR BRNC W ACT EXA	33
4918	CHRONIC BRONCHITIS NEC	33
4919	CHRONIC BRONCHITIS NOS	33
4920	EMPHYSEMATOUS BLEB	33
4928	EMPHYSEMA NEC	33
49300	EXT ASTHMA W/O STAT ASTH	33
49301	EXT ASTHMA W STATUS ASTH	78
49310	INT ASTHMA W/O STAT ASTH	33
49311	INT ASTHMA W STATUS ASTH	78
49320	CH OB ASTH W/O STAT ASTH	33
49321	CH OB ASTHMA W STAT ASTH	78
49390	ASTHMA W/O STATUS ASTHM	33
49391	ASTHMA W STATUS ASTHMAT	78
494	BRONCHIECTASIS	33
4950	FARMERS' LUNG	33
4951	BAGASSOSIS	33
4952	BIRD-FANCIERS' LUNG	33
4953	SUBEROSIS	33
4954	MALT WORKERS' LUNG	33
4955	MUSHROOM WORKERS' LUNG	33
4956	MAPL BARK-STRIPPRS' LUNG	33
4957	''VENTILATION'' PNEUMONIT	33
4958	ALLERG ALVEOL/PNEUM NEC	33

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
4959	ALLERG ALVEOL/PNEUM NOS	33
496	CHR AIRWAY OBSTRUCT NEC	33
500	COAL WORKERS' PNEUMOCON	33
501	ASBESTOSIS	33
502	SILICA PNEUMOCON NEC	33
503	INORG DUST PNEUMOCON NEC	33
504	DUST PNEUMONOPATHY NEC	33
505	PNEUMOCONIOSIS NOS	33
5060	FUM/VAPOR BRONC/PNEUMON	33
5061	FUM/VAPOR AC PULM EDEMA	33
5062	FUM/VAPOR UP RESP INFLAM	33
5063	FUM/VAP AC RESP COND NEC	33
5064	FUM/VAPOR CHR RESP COND	33
5069	FUM/VAPOR RESP COND NOS	33
5070	FOOD/VOMIT PNEUMONITIS	33
5071	OIL/ESSENCE PNEUMONITIS	33
5078	SOLID/LIQ PNEUMONIT NEC	33
5080	AC PUL MANIF D/T RADIAT	33
5081	CHR PUL MANIF D/T RADIAT	33
5088	RESP COND: EXT AGENT NEC	33
5089	RESP COND: EXT AGENT NOS	33
5100	EMPYEMA WITH FISTULA	33
5109	EMPYEMA W/O FISTULA	33
5110	PLEURISY W/O EFFUS OR TB	33
5111	BACT PLEUR/EFFUS NOT TB	33
5118	PLEURAL EFFUS NEC NOT TB	33
5119	PLEURAL EFFUSION NOS	33
5120	SPONT TENS PNEUMOTHORAX	33
5121	IATROGENIC PNEUMOTHORAX	78
5128	SPONT PNEUMOTHORAX NEC	33
5130	ABSCESS OF LUNG	33
5131	ABSCESS OF MEDIASTINUM	33
514	PULM CONGEST/HYPOSTASIS	33
515	POSTINFLAM PULM FIBROSIS	33
5160	PUL ALVEOLAR PROTEINOSIS	33
5161	IDIO PULM HEMOSIDEROSIS	33
5162	PULM ALVEOLAR MICROLITH	33
5163	IDIO FIBROS ALVEOLITIS	33
5168	ALVEOL PNEUMONOPATHY NEC	33
5169	ALVEOL PNEUMONOPATHY NOS	33
5171	RHEUMATIC PNEUMONIA	33
5172	SYST SCLEROSIS LUNG DIS	33
5178	LUNG INVOLV IN OTH DIS	33
5180	PULMONARY COLLAPSE	33
5181	INTERSTITIAL EMPHYSEMA	33
5182	COMPENSATORY EMPHYSEMA	33
5183	PULMONARY EOSINOPHILIA	33
5184	ACUTE LUNG EDEMA NOS	33
5185	POST TRAUM PULM INSUFFIC	33
51881	RESPIRATORY FAILURE	33
51882	OTHER PULMONARY INSUFF	33
51889	OTHER LUNG DISEASE NEC	33
5190	TRACHEOSTOMY COMPLIC	33
5191	TRACHEA/BRONCHUS DIS NEC	33
5192	MEDIASTINITIS	33
5193	MEDIASTINUM DISEASE NEC	33
5194	DISORDERS OF DIAPHRAGM	33
5198	RESP SYSTEM DISEASE NEC	11
5199	RESP SYSTEM DISEASE NOS	11
5200	ANODONTIA	31
5201	SUPERNUMERARY TEETH	31
5202	ABNORMAL TOOTH SIZE/FORM	31
5203	MOTTLED TEETH	31
5204	TOOTH FORMATION DISTURB	31
5205	HEREDIT TOOTH STRUCT NEC	31
5206	TOOTH ERUPTION DISTURB	31
5207	TEETHING SYNDROME	31
5208	TOOTH DEVEL/ERUP DIS NEC	31
5209	TOOTH DEVEL/ERUP DIS NOS	31
5210	DENTAL CARIES	31
5211	EXCESS ATTRITION-TEETH	31
5212	ABRASION OF TEETH	31
5213	EROSION OF TEETH	31
5214	RESORPTION OF TEETH	31
5215	HYPERCEMENTOSIS	31
5216	ANKYLOSIS OF TEETH	31

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
5217	POSTERUPT COLOR CHANGE	31
5218	HARD TISS DIS TEETH NEC	31
5219	HARD TISS DIS TEETH NOS	31
5220	PULPITIS	31
5221	NECROSIS OF TOOTH PULP	31
5222	TOOTH PULP DEGENERATION	31
5223	ABN HARD TISS-TOOTH PULP	31
5224	AC APICAL PERIODONTITIS	31
5225	PERIAPICAL ABSCESS	31
5226	CHR APICAL PERIODONTITIS	31
5227	PERIAPICAL ABSC W SINUS	31
5228	RADICULAR CYST	31
5229	PULP/PERIAPICAL DIS NEC	31
5230	ACUTE GINGIVITIS	31
5231	CHRONIC GINGIVITIS	31
5232	GINGIVAL RECESSION	31
5233	ACUTE PERIODONTITIS	31
5234	CHRONIC PERIODONTITIS	31
5235	PERIODONTOSIS	31
5236	ACCRETIONS ON TEETH	31
5238	PERIODONTAL DISEASE NEC	31
5239	GINGIV/PERIODONT DIS NOS	31
52400	UNSPCF ANOMALY JAW SIZE	31
52401	MAXILLARY HYPERPLASIA	31
52402	MANDIBULAR HYPERPLASIA	31
52403	MAXILLARY HYPOPLASIA	31
52404	MANDIBULAR HYPOPLASIA	31
52405	MACROGENIA	31
52406	MICROGENIA	31
52409	OTH SPCF ANMLY JAW SIZE	31
52410	UNSPCF ANM JAW CRANL BSE	31
52411	MAXILLARY ASYMMETRY	31
52412	OTHER JAW ASYMMETRY	31
52419	SPCFD ANOM JAW CRANL BSE	31
5242	DENTAL ARCH ANOMALY	31
5243	TOOTH POSITION ANOMALY	31
5244	MALOCCLUSION NOS	31
5245	ABN DENTOFACIAL FUNCTION	31
52460	TMJ DISORDERS NOS	24
52461	ADHESNS/ANKYLOSIS—TMJ	24
52462	ARTHRALGIA TMJ	24
52463	ARTICULAR DISC DISORDER	24
52469	OTHER SPECF TMJ DISORDRS	24
52470	UNSPF DENT ALVELR ANMALY	31
52471	ALVEOLAR MAXIL HYPRPLSIA	31
52472	ALVEOLAR MANDIB HYPRPLAS	31
52473	ALVEOLAR MAXIL HYPOPLSIA	31
52474	ALVEOLAR MANDB HYPOPLSIA	31
52479	OTH SPCF ALVEOLAR ANMALY	31
5248	DENTOFACIAL ANOMALY NEC	31
5249	DENTOFACIAL ANOMALY NOS	31
5250	EXFOLIATION OF TEETH	31
5251	LOSS OF TEETH, ACQUIRED	31
5252	ATROPHY ALVEOLAR RIDGE	31
5253	RETAINED DENTAL ROOT	31
5258	DENTAL DISORDER NEC	31
5259	DENTAL DISORDER NOS	31
5260	DEVEL ODONTOGENIC CYSTS	31
5261	FISSURAL CYSTS OF JAW	31
5262	CYSTS OF JAWS NEC	31
5263	CENT GIANT CELL GRANULOM	31
5264	INFLAMMATION OF JAW	31
5265	ALVEOLITIS OF JAW	31
52681	EXOSTOSIS OF JAW	31
52689	JAW DISEASE NEC	31
5269	JAW DISEASE NOS	31
5270	SALIVARY GLAND ATROPHY	31
5271	SALIVARY GLND HYPRTROPHY	31
5272	SIALOADENITIS	31
5273	SALIVARY GLAND ABSCESS	31
5274	SALIVARY GLAND FISTULA	31
5275	SIALOLITHIASIS	31
5276	SALIVARY GLAND MUCOCELE	31
5277	SALIVARY SECRETION DIS	31
5278	SALIVARY GLAND DIS NEC	31
5279	SALIVARY GLAND DIS NOS	31

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
5280	STOMATITIS	31
5281	CANCRUM ORIS	31
5282	ORAL APHTHAE	31
5283	CELLULITIS/ABSCESS MOUTH	31
5284	ORAL SOFT TISSUE CYST	31
5285	DISEASES OF LIPS	31
5286	LEUKOPLAKIA ORAL MUCOSA	31
5287	ORAL EPITHELIUM DIS NEC	31
5288	ORAL SUBMUCOSAL FIBROSIS	31
5289	ORAL SOFT TISSUE DIS NEC	31
5290	GLOSSITIS	31
5291	GEOGRAPHIC TONGUE	31
5292	MED RHOMBOID GLOSSITIS	31
5293	HYPERTROPH TONGUE PAPILL	31
5294	ATROPHY TONGUE PAPILLAE	31
5295	PLICATED TONGUE	31
5296	GLOSSODYNIA	31
5298	TONGUE DISORDER NEC	31
5299	TONGUE DISORDER NOS	31
5300	ACHALASIA & CARDIOSPASM	41
53010	ESOPHAGITIS, UNSPECIFIED	41
53011	REFLUX ESOPHAGITIS	41
53019	OTHER ESOPHAGITIS	41
5302	ULCER OF ESOPHAGUS	41
5303	ESOPHAGEAL STRICTURE	41
5304	PERFORATION OF ESOPHAGUS	41
5305	DYSKINESIA OF ESOPHAGUS	41
5306	ACQ ESOPHAG DIVERTICULUM	41
5307	MALLORY-WEISS SYNDROME	41
53081	ESOPHAGEAL REFLUX	41
53082	ESOPHAGEAL HEMORRHAGE	41
53083	ESOPHAGEAL LEUKOPLAKIA	41
53084	TRACHEOESOPHAGEAL FSTULA	41
53089	OTHER DSRDERS ESOPHAGUS	41
5309	ESOPHAGEAL DISORDER NOS	41
53100	AC STOMACH ULCER W HEM	41
53101	AC STOMAC ULC W HEM-OBST	41
53110	AC STOMACH ULCER W PERF	78
53111	AC STOM ULC W PERF-OBST	78
53120	AC STOMAC ULC W HEM/PERF	78
53121	AC STOM ULC HEM/PERF-OBS	78
53130	ACUTE STOMACH ULCER NOS	41
53131	AC STOMACH ULC NOS-OBSTR	41
53140	CHR STOMACH ULC W HEM	41
53141	CHR STOM ULC W HEM-OBSTR	41
53150	CHR STOMACH ULCER W PERF	78
53151	CHR STOM ULC W PERF-OBST	78
53160	CHR STOMACH ULC HEM/PERF	78
53161	CHR STOM ULC HEM/PERF-OB	78
53170	CHR STOMACH ULCER NOS	41
53171	CHR STOMACH ULC NOS-OBST	41
53190	STOMACH ULCER NOS	41
53191	STOMACH ULCER NOS-OBSTR	41
53200	AC DUODENAL ULCER W HEM	41
53201	AC DUODEN ULC W HEM-OBST	41
53210	AC DUODENAL ULCER W PERF	78
53211	AC DUODEN ULC PERF-OBSTR	78
53220	AC DUODEN ULC W HEM/PERF	78
53221	AC DUOD ULC HEM/PERF-OBS	78
53230	ACUTE DUODENAL ULCER NOS	41
53231	AC DUODENAL ULC NOS-OBST	41
53240	CHR DUODEN ULCER W HEM	41
53241	CHR DUODEN ULC HEM-OBSTR	41
53250	CHR DUODEN ULCER W PERF	78
53251	CHR DUODEN ULC PERF-OBST	78
53260	CHR DUODEN ULC HEM/PERF	78
53261	CHR DUOD ULC HEM/PERF-OB	78
53270	CHR DUODENAL ULCER NOS	41
53271	CHR DUODEN ULC NOS-OBSTR	41
53290	DUODENAL ULCER NOS	41
53291	DUODENAL ULCER NOS-OBSTR	41
53300	AC PEPTIC ULCER W HEMORR	41
53301	AC PEPTIC ULC W HEM-OBST	41
53310	AC PEPTIC ULCER W PERFOR	78
53311	AC PEPTIC ULC W PERF-OBS	78
53320	AC PEPTIC ULC W HEM/PERF	78

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
53321	AC PEPT ULC HEM/PERF-OBS	78
53330	ACUTE PEPTIC ULCER NOS	41
53331	AC PEPTIC ULCER NOS-OBST	41
53340	CHR PEPTIC ULCER W HEM	41
53341	CHR PEPTIC ULC W HEM-OBS	41
53350	CHR PEPTIC ULCER W PERF	78
53351	CHR PEPTIC ULC PERF-OBST	78
53360	CHR PEPT ULC W HEM/PERF	78
53361	CHR PEPT ULC HEM/PERF-OB	78
53370	CHRONIC PEPTIC ULCER NOS	41
53371	CHR PEPTIC ULCER NOS-OBS	41
53390	PEPTIC ULCER NOS	41
53391	PEPTIC ULCER NOS-OBSTRUC	41
53400	AC MARGINAL ULCER W HEM	41
53401	AC MARGIN ULC W HEM-OBST	41
53410	AC MARGINAL ULCER W PERF	78
53411	AC MARGIN ULC W PERF-OBS	78
53420	AC MARGIN ULC W HEM/PERF	78
53421	AC MARG ULC HEM/PERF-OBS	78
53430	AC MARGINAL ULCER NOS	41
53431	AC MARGINAL ULC NOS-OBST	41
53440	CHR MARGINAL ULCER W HEM	41
53441	CHR MARGIN ULC W HEM-OBS	41
53450	CHR MARGINAL ULC W PERF	78
53451	CHR MARGIN ULC PERF-OBST	78
53460	CHR MARGIN ULC HEM/PERF	78
53461	CHR MARG ULC HEM/PERF-OB	78
53470	CHR MARGINAL ULCER NOS	41
53471	CHR MARGINAL ULC NOS-OBS	41
53490	GASTROJEJUNAL ULCER NOS	41
53491	GASTROJEJUN ULC NOS-OBST	41
53500	ACUTE GASTRTIS W/O HMRHG	41
53501	ACUTE GASTRITIS W HMRHG	41
53510	ATRPH GASTRTIS W/O HMRHG	41
53511	ATRPH GASTRITIS W HMRHG	41
53520	GSTR MCSL HYPRT W/O HMRG	41
53521	GSTR MCSL HYPRT W HMRG	41
53530	ALCHL GASTRTIS W/O HMRHG	41
53531	ALCHL GSTRITIS W HMRHG	41
53540	OTH SPF GSTRT W/O HMRHG	41
53541	OTH SPF GASTRT W HMRHG	41
53550	GSTR/DDNTS NOS W/O HMRHG	41
53551	GSTR/DDNTS NOS W HMRHG	41
53560	DUODENITIS W/O HMRHG	41
53561	DUODENITIS W HMRHG	41
5360	ACHLORHYDRIA	41
5361	AC DILATION OF STOMACH	41
5362	PERSISTENT VOMITING	41
5363	GASTROPARESIS	41
5368	STOMACH FUNCTION DIS NEC	41
5369	STOMACH FUNCTION DIS NOS	41
5370	ACQ PYLORIC STENOSIS	41
5371	GASTRIC DIVERTICULUM	41
5372	CHRONIC DUODENAL ILEUS	41
5373	DUODENAL OBSTRUCTION NEC	41
5374	GASTRIC/DUODENAL FISTULA	41
5375	GASTROPTOSIS	41
5376	HOURGLASS STRICTURE STOM	41
53781	PYLOROSPASM	41
53782	ANGIO STM/DUDN W/O HMRHG	41
53783	ANGIO STM/DUDN W HMRHG	41
53789	GASTRODUODENAL DIS NEC	41
5379	GASTRODUODENAL DIS NOS	41
5400	AC APPEND W PERITONITIS	41
5401	ABSCESS OF APPENDIX	41
5409	ACUTE APPENDICITIS NOS	41
541	APPENDICITIS NOS	41
542	OTHER APPENDICITIS	41
5430	HYPERPLASIA OF APPENDIX	41
5439	DISEASES OF APPENDIX NEC	41
55000	UNILAT ING HERNIA W GANG	41
55001	RECUR UNIL ING HERN-GANG	41
55002	BILAT ING HERNIA W GANG	41
55003	RECUR BIL ING HERN-GANG	41
55010	UNILAT ING HERNIA W OBST	41
55011	RECUR UNIL ING HERN-OBST	41

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
55012	BILAT ING HERNIA W OBST	41
55013	RECUR BIL ING HERN-OBSTR	41
55090	UNILAT INGUINAL HERNIA	41
55091	RECUR UNILAT INGUIN HERN	41
55092	BILAT INGUINAL HERNIA	41
55093	RECUR BILAT INGUIN HERN	41
55100	UNIL FEMORAL HERN W GANG	41
55101	REC UNIL FEM HERN W GANG	41
55102	BILAT FEM HERN W GANG	41
55103	RECUR BIL FEM HERN-GANG	41
5511	UMBILICAL HERNIA W GANGR	41
55120	GANGR VENTRAL HERNIA NOS	41
55121	GANGR INCISIONAL HERNIA	41
55129	GANG VENTRAL HERNIA NEC	41
5513	DIAPHRAGM HERNIA W GANGR	78
5518	HERNIA, SITE NEC W GANGR	78
5519	HERNIA, SITE NOS W GANGR	78
55200	UNIL FEMORAL HERN W OBST	41
55201	REC UNIL FEM HERN W OBST	41
55202	BIL FEMORAL HERN W OBSTR	41
55203	REC BIL FEM HERN W OBSTR	41
5521	UMBILICAL HERNIA W OBSTR	41
55220	OBSTR VENTRAL HERNIA NOS	41
55221	OBSTR INCISIONAL HERNIA	41
55229	OBSTR VENTRAL HERNIA NEC	41
5523	DIAPHRAGM HERNIA W OBSTR	41
5528	HERNIA, SITE NEC W OBSTR	41
5529	HERNIA, SITE NOS W OBSTR	41
55300	UNILAT FEMORAL HERNIA	41
55301	RECUR UNIL FEMORAL HERN	41
55302	BILATERAL FEMORAL HERNIA	41
55303	RECUR BILAT FEMORAL HERN	41
5531	UMBILICAL HERNIA	41
55320	VENTRAL HERNIA NOS	41
55321	INCISIONAL HERNIA	41
55329	VENTRAL HERNIA NEC	41
5533	DIAPHRAGMATIC HERNIA	41
5538	HERNIA NEC	41
5539	HERNIA NOS	41
5550	REG ENTERITIS, SM INTEST	41
5551	REG ENTERITIS, LG INTEST	41
5552	REG ENTERIT SM/LG INTEST	41
5559	REGIONAL ENTERITIS NOS	41
5560	ULCERATIVE ENTEROCOLITIS	41
5561	ULCERATIVE ILEOCOLITIS	41
5562	ULCERATIVE PROCTITIS	41
5563	ULCERTVE PRCTOSIGMOIDTIS	41
5564	PSEUDOPOLYPOSIS COLON	41
5565	LFTSDED ULCERTVE COLITIS	41
5566	UNIVRSL ULCERTVE COLITIS	41
5568	OTHER ULCERATIVE COLITIS	41
5569	ULCERATVE COLITIS UNSPCF	41
5570	AC VASC INSUFF INTESTINE	41
5571	CHR VASC INSUFF INTEST	41
5579	VASC INSUFF INTEST NOS	41
5581	RADIATION GASTROENTERIT	41
5582	TOXIC GASTROENTERITIS	41
5589	NONINF GASTROENTERIT NEC	41
5600	INTUSSUSCEPTION	41
5601	PARALYTIC ILEUS	41
5602	VOLVULUS OF INTESTINE	41
56030	IMPACTION INTESTINE NOS	41
56031	GALLSTONE ILEUS	41
56039	IMPACTION INTESTINE NEC	41
56081	INTESTINAL ADHES W OBSTR	41
56089	INTESTINAL OBSTRUCT NEC	41
5609	INTESTINAL OBSTRUCT NOS	41
56200	DVRTCLO SML INT W/O HMRG	41
56201	DVRTCLI SML INT W/O HMRG	41
56202	DVRTCLO SML INT W HMRHG	41
56203	DVRTCLI SML INT W HMRHG	41
56210	DVRTCLO COLON W/O HMRHG	41
56211	DVRTCLI COLON W/O HMRHG	41
56212	DVRTCLO COLON W HMRHG	41
56213	DVRTCLI COLON W HMRHG	41
5640	CONSTIPATION	41

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
5641	IRRITABLE COLON	41
5642	POSTGASTRIC SURGERY SYND	41
5643	VOMITING POST-GI SURGERY	41
5644	POSTOP GI FUNCT DIS NEC	41
5645	FUNCTIONAL DIARRHEA	41
5646	ANAL SPASM	41
5647	MEGACOLON NEC	41
5648	FUNCT DIS INTESTINE NEC	41
5649	FUNCT DIS INTESTINE NOS	41
5650	ANAL FISSURE	41
5651	ANAL FISTULA	41
566	ANAL & RECTAL ABSCESS	41
5670	PERITONITIS IN INFEC DIS	41
5671	PNEUMOCOCCAL PERITONITIS	41
5672	SUPPURAT PERITONITIS NEC	41
5678	PERITONITIS NEC	41
5679	PERITONITIS NOS	41
5680	PERITONEAL ADHESIONS	41
56881	HEMOPERITONEUM	78
56882	PERITONEAL EFFUSION	41
56889	PERITONEAL DISORDER NEC	41
5689	PERITONEAL DISORDER NOS	41
5690	ANAL & RECTAL POLYP	41
5691	RECTAL PROLAPSE	41
5692	RECTAL & ANAL STENOSIS	41
5693	RECTAL & ANAL HEMORRHAGE	41
56941	RECTAL & ANAL ULCER	41
56942	ANAL OR RECTAL PAIN	41
56949	RECTAL & ANAL DIS NEC	41
5695	INTESTINAL ABSCESS	41
56960	COLSTOMY/ENTER COMP NOS	41
56961	COLOSTY/ENTEROST INFECTN	41
56969	COLSTMY/ENTEROS COMP NEC	41
56981	INTESTINAL FISTULA	41
56982	ULCERATION OF INTESTINE	41
56983	PERFORATION OF INTESTINE	41
56984	ANGIO INTES W/O HMRHG	41
56985	ANGIO INTES W HMRHG	41
56989	INTESTINAL DISORDERS NEC	41
5699	INTESTINAL DISORDER NOS	41
570	ACUTE NECROSIS OF LIVER	41
5710	ALCOHOLIC FATTY LIVER	41
5711	AC ALCOHOLIC HEPATITIS	41
5712	ALCOHOL CIRRHOSIS LIVER	41
5713	ALCOHOL LIVER DAMAGE NOS	41
57140	CHRONIC HEPATITIS NOS	41
57141	CHR PERSISTENT HEPATITIS	41
57149	CHRONIC HEPATITIS NEC	41
5715	CIRRHOSIS OF LIVER NOS	41
5716	BILIARY CIRRHOSIS	41
5718	CHRONIC LIVER DIS NEC	41
5719	CHRONIC LIVER DIS NOS	41
5720	ABSCESS OF LIVER	41
5721	PORTAL PYEMIA	41
5722	HEPATIC COMA	78
5723	PORTAL HYPERTENSION	41
5724	HEPATORENAL SYNDROME	41
5728	OTH SEQUELA, CHR LIV DIS	41
5730	CHR PASSIV CONGEST LIVER	41
5731	HEPATITIS IN VIRAL DIS	41
5732	HEPATITIS IN OTH INF DIS	41
5733	HEPATITIS NOS	41
5734	HEPATIC INFARCTION	41
5738	LIVER DISORDERS NEC	41
5739	LIVER DISORDER NOS	41
57400	CHOLELITH W AC CHOLECYST	41
57401	CHOLELITH/AC GB INF-OBST	41
57410	CHOLELITH W CHOLECYS NEC	41
57411	CHOLELITH/GB INF NEC-OBS	41
57420	CHOLELITHIASIS NOS	41
57421	CHOLELITHIAS NOS W OBSTR	41
57430	CHOLEDOCHOLITH/AC GB INF	41
57431	CHOLEDOCHLITH/AC GB-OBST	41
57440	CHOLEDOCHLITH/GB INF NEC	41
57441	CHOLEDOCHLITH/GB NEC-OBS	41
57450	CHOLEDOCHOLITHIASIS NOS	41

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
57451	CHOLEDOCHLITH NOS W OBST	41
5750	ACUTE CHOLECYSTITIS	41
5752	OBSTRUCTION GALLBLADDER	41
5753	HYDROPS OF GALLBLADDER	41
5754	PERFORATION GALLBLADDER	41
5755	FISTULA OF GALLBLADDER	41
5756	GB CHOLESTEROLOSIS	41
5758	DIS OF GALLBLADDER NEC	41
5759	DIS OF GALLBLADDER NOS	41
5760	POSTCHOLECYSTECTOMY SYND	41
5761	CHOLANGITIS	41
5762	OBSTRUCTION OF BILE DUCT	41
5763	PERFORATION OF BILE DUCT	41
5764	FISTULA OF BILE DUCT	41
5765	SPASM SPHINCTER OF ODDI	41
5768	DIS OF BILIARY TRACT NEC	41
5769	DIS OF BILIARY TRACT NOS	41
5770	ACUTE PANCREATITIS	41
5771	CHRONIC PANCREATITIS	41
5772	PANCREAT CYST/PSEUDOCYST	41
5778	PANCREATIC DISEASE NEC	41
5779	PANCREATIC DISEASE NOS	41
5780	HEMATEMESIS	41
5781	BLOOD IN STOOL	41
5789	GASTROINTEST HEMORR NOS	41
5790	CELIAC DISEASE	41
5791	TROPICAL SPRUE	41
5792	BLIND LOOP SYNDROME	41
5793	INTEST POSTOP NONABSORB	41
5794	PANCREATIC STEATORRHEA	41
5798	INTEST MALABSORPTION NEC	41
5799	INTEST MALABSORPTION NOS	41
5800	AC PROLIFERAT NEPHRITIS	53
5804	AC RAPIDLY PROGR NEPHRIT	53
58081	AC NEPHRITIS IN OTH DIS	53
58089	ACUTE NEPHRITIS NEC	53
5809	ACUTE NEPHRITIS NOS	53
5810	NEPHROTIC SYN, PROLIFER	53
5811	EPIMEMBRANOUS NEPHRITIS	53
5812	MEMBRANOPROLIF NEPHROSIS	53
5813	MINIMAL CHANGE NEPHROSIS	53
58181	NEPHROTIC SYN IN OTH DIS	53
58189	NEPHROTIC SYNDROME NEC	53
5819	NEPHROTIC SYNDROME NOS	53
5820	CHR PROLIFERAT NEPHRITIS	53
5821	CHR MEMBRANOUS NEPHRITIS	53
5822	CHR MEMBRANOPROLIF NEPHR	53
5824	CHR RAPID PROGR NEPHRIT	53
58281	CHR NEPHRITIS IN OTH DIS	53
58289	CHRONIC NEPHRITIS NEC	53
5829	CHRONIC NEPHRITIS NOS	53
5830	PROLIFERAT NEPHRITIS NOS	53
5831	MEMBRANOUS NEPHRITIS NOS	53
5832	MEMBRANOPROLIF NEPHR NOS	53
5834	RAPIDLY PROG NEPHRIT NOS	53
5836	RENAL CORT NECROSIS NOS	53
5837	NEPHR NOS/MEDULL NECROS	53
58381	NEPHRITIS NOS IN OTH DIS	53
58389	NEPHRITIS NEC	53
5839	NEPHRITIS NOS	53
5845	LOWER NEPHRON NEPHROSIS	53
5846	AC RENAL FAIL, CORT NECR	53
5847	AC REN FAIL, MEDULL NECR	53
5848	AC RENAL FAILURE NEC	53
5849	ACUTE RENAL FAILURE NOS	53
585	CHRONIC RENAL FAILURE	53
586	RENAL FAILURE NOS	53
587	RENAL SCLEROSIS NOS	53
5880	RENAL OSTEODYSTROPHY	53
5881	NEPHROGEN DIABETES INSIP	53
5888	IMPAIRED RENAL FUNCT NEC	53
5889	IMPAIRED RENAL FUNCT NOS	53
5890	UNILATERAL SMALL KIDNEY	53
5891	BILATERAL SMALL KIDNEYS	53
5899	SMALL KIDNEY NOS	53
59000	CHR PYELONEPHRITIS NOS	53

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
59001	CHR PYELONEPH W MED NECR	53
59010	AC PYELONEPHRITIS NOS	53
59011	AC PYELONEPHR W MED NECR	53
5902	RENAL/PERIRENAL ABSCESS	53
5903	PYELOURETERITIS CYSTICA	53
59080	PYELONEPHRITIS NOS	53
59081	PYELONEPHRIT IN OTH DIS	53
5909	INFECTION OF KIDNEY NOS	53
591	HYDRONEPHROSIS	53
5920	CALCULUS OF KIDNEY	53
5921	CALCULUS OF URETER	53
5929	URINARY CALCULUS NOS	53
5930	NEPHROPTOSIS	53
5931	HYPERTROPHY OF KIDNEY	53
5932	CYST OF KIDNEY, ACQUIRED	53
5933	STRICTURE OF URETER	53
5934	URETERIC OBSTRUCTION NEC	53
5935	HYDROURETER	53
5936	POSTURAL PROTEINURIA	53
59370	VESCOURETRL RFLUX UNSPCF	53
59371	VSCURT RFLX NPHT UNILTRL	53
59372	VSCOURTL RFLX NPHT BLTRL	53
59373	VSCOURTL RFLX W NPHT NOS	53
59381	RENAL VASCULAR DISORDER	53
59382	URETERAL FISTULA	53
59389	RENAL & URETERAL DIS NEC	53
5939	RENAL & URETERAL DIS NOS	53
5940	BLAD DIVERTICULUM CALCUL	53
5941	BLADDER CALCULUS NEC	53
5942	URETHRAL CALCULUS	53
5948	LOWER URIN CALCUL NEC	53
5949	LOWER URIN CALCUL NOS	53
5950	ACUTE CYSTITIS	53
5951	CHR INTERSTIT CYSTITIS	53
5952	CHRONIC CYSTITIS NEC	53
5953	TRIGONITIS	53
5954	CYSTITIS IN OTH DIS	53
59581	CYSTITIS CYSTICA	53
59582	IRRADIATION CYSTITIS	53
59589	CYSTITIS NEC	53
5959	CYSTITIS NOS	53
5960	BLADDER NECK OBSTRUCTION	53
5961	INTESTINOVESICAL FISTULA	53
5962	VESICAL FISTULA NEC	53
5963	DIVERTICULUM OF BLADDER	53
5964	ATONY OF BLADDER	53
59651	HYPERTONICITY OF BLADDER	53
59652	LOW BLADDER COMPLIANCE	53
59653	PARALYSIS OF BLADDER	53
59654	NEUROGENIC BLADDER NOS	53
59655	DETRUSR SPHINC DYSSNRGIA	53
59659	OTH FUNC DSDR BLADDER	53
5966	BLADDER RUPT, NONTRAUM	53
5967	BLADDER WALL HEMORRHAGE	53
5968	BLADDER DISORDER NEC	53
5969	BLADDER DISORDER NOS	53
5970	URETHRAL ABSCESS	53
59780	URETHRITIS NOS	53
59781	URETHRAL SYNDROME NOS	53
59789	URETHRITIS NEC	53
59800	URETHR STRICT:INFECT NOS	53
59801	URETH STRICT:OTH INFECT	53
5981	TRAUM URETHRAL STRICTURE	53
5982	POSTOP URETHRAL STRICTUR	53
5988	URETHRAL STRICTURE NEC	53
5989	URETHRAL STRICTURE NOS	53
5990	URIN TRACT INFECTION NOS	53
5991	URETHRAL FISTULA	53
5992	URETHRAL DIVERTICULUM	53
5993	URETHRAL CARUNCLE	53
5994	URETHRAL FALSE PASSAGE	53
5995	PROLAPSE URETHRAL MUCOSA	53
5996	URINARY OBSTRUCTION NOS	53
5997	HEMATURIA	53
5998	URINARY TRACT DIS NEC*	53
59981	URETHRAL HYPERMOBILITY	53

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
59982	INTRINSC SPHNCTR DFICNCY	53
59983	URETHRAL INSTABILITY	53
59984	OTH SPCF DSDR URETHRA	53
59989	OTH SPCF DSDR URNRY TRCT	53
5999	URINARY TRACT DIS NOS	53
600	HYPERPLASIA OF PROSTATE	53
6010	ACUTE PROSTATITIS	53
6011	CHRONIC PROSTATITIS	53
6012	ABSCESS OF PROSTATE	53
6013	PROSTATOCYSTITIS	53
6014	PROSTATITIS IN OTH DIS	53
6018	PROSTATIC INFLAM DIS NEC	53
6019	PROSTATITIS NOS	53
6020	CALCULUS OF PROSTATE	53
6021	PROSTATIC CONGEST/HEMORR	53
6022	ATROPHY OF PROSTATE	53
6028	PROSTATIC DISORDERS NEC	53
6029	PROSTATIC DISORDER NOS	53
6030	ENCYSTED HYDROCELE	53
6031	INFECTED HYDROCELE	53
6038	HYDROCELE NEC	53
6039	HYDROCELE NOS	53
6040	ORCHITIS WITH ABSCESS	53
60490	ORCHITIS/EPIDIDYMIT NOS	53
60491	ORCHITIS IN OTH DISEASE	53
60499	ORCHITIS/EPIDIDYMIT NEC	53
605	REDUN PREPUCE & PHIMOSIS	53
6060	AZOOSPERMIA	53
6061	OLIGOSPERMIA	53
6068	MALE INFERTILITY NEC	53
6069	MALE INFERTILITY NOS	53
6070	LEUKOPLAKIA OF PENIS	53
6071	BALANOPOSTHITIS	53
6072	INFLAM DIS, PENIS NEC	53
6073	PRIAPISM	53
60781	BALANITIS XEROTICA OBLIT	53
60782	VASCULAR DISORDER, PENIS	53
60783	EDEMA OF PENIS	53
60784	IMPOTENCE, ORGANIC ORIGN	53
60789	DISORDER OF PENIS NEC	53
6079	DISORDER OF PENIS NOS	53
6080	SEMINAL VESICULITIS	97
6081	SPERMATOCELE	53
6082	TORSION OF TESTIS	53
6083	ATROPHY OF TESTIS	53
6084	MALE GEN INFLAM DIS NEC	53
60881	MALE GEN DIS IN OTH DIS	53
60883	MALE GEN VASCUL DIS NEC	53
60884	CHYLOCELE, TUNIC VAGINAL	53
60885	STRICTURE, MALE GEN ORGN	53
60886	EDEMA, MALE GENITAL ORGN	53
60889	MALE GENITAL DIS NEC	53
6089	MALE GENITAL DIS NOS	53
6100	SOLITARY CYST OF BREAST	18
6101	DIFFUS CYSTIC MASTOPATHY	18
6102	FIBROADENOSIS OF BREAST	18
6103	FIBROSCLEROSIS OF BREAST	18
6104	MAMMARY DUCT ECTASIA	18
6108	BENIGN MAMM DYSPLAS NEC	18
6109	BENIGN MAMM DYSPLAS NOS	18
6110	INFLAM DISEASE OF BREAST	18
6111	HYPERTROPHY OF BREAST	18
6112	FISSURE OF NIPPLE	18
6113	FAT NECROSIS OF BREAST	18
6114	ATROPHY OF BREAST	18
6115	GALACTOCELE	18
6116	GALACTORRHEA-NONOBSTET	18
61171	MASTODYNIA	18
61172	LUMP OR MASS IN BREAST	18
61179	SYMPTOMS IN BREAST NEC	18
6118	BREAST DISORDERS NEC	18
6119	BREAST DISORDER NOS	18
6140	AC SALPINGO-OOPHORITIS	97
6141	CHR SALPINGO-OOPHORITIS	97
6142	SALPINGO-OOPHORITIS NOS	97
6143	ACUTE PARAMETRITIS	56

*ICD–9 Codes preceded by an asterisk are codes that are not valid as a reason for the visit.

ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
6144	CHRONIC PARAMETRITIS	56
6145	AC PELV PERITONITIS-FEM	56
6146	FEM PELVIC PERITON ADHES	56
6147	CHR PELV PERITON NEC-FEM	56
6148	FEM PELV INFLAM DIS NEC	97
6149	FEM PELV INFLAM DIS NOS	97
6150	AC UTERINE INFLAMMATION	56
6151	CHR UTERINE INFLAMMATION	56
6159	UTERINE INFLAM DIS NOS	56
6160	CERVICITIS	97
61610	VAGINITIS NOS	97
61611	VAGINITIS IN OTH DISEASE	97
6162	BARTHOLIN'S GLAND CYST	56
6163	BARTHOLIN'S GLND ABSCESS	56
6164	ABSCESS OF VULVA NEC	56
61650	ULCERATION OF VULVA NOS	56
61651	VULVAR ULCER IN OTH DIS	56
6168	FEMALE GEN INFLAM NEC	56
6169	FEMALE GEN INFLAM NOS	56
6170	UTERINE ENDOMETRIOSIS	56
6171	OVARIAN ENDOMETRIOSIS	56
6172	TUBAL ENDOMETRIOSIS	56
6173	PELV PERIT ENDOMETRIOSIS	56
6174	VAGINAL ENDOMETRIOSIS	56
6175	INTESTINAL ENDOMETRIOSIS	41
6176	ENDOMETRIOSIS IN SCAR	18
6178	ENDOMETRIOSIS NEC	56
6179	ENDOMETRIOSIS NOS	56
6180	PROLAPSE OF VAGINAL WALL	56
6181	UTERINE PROLAPSE	56
6182	UTEROVAG PROLAPS-INCOMPL	56
6183	UTEROVAG PROLAPS-COMPLET	56
6184	UTERVAGINAL PROLAPSE NOS	56
6185	POSTOP VAGINAL PROLAPSE	56
6186	VAGINAL ENTEROCELE	56
6187	OLD LACER PELVIC MUSCLE	56
6188	GENITAL PROLAPSE NEC	56
6189	GENITAL PROLAPSE NOS	56
6190	URIN-GENITAL FISTUL, FEM	56
6191	DIGEST-GENIT FISTUL, FEM	41
6192	GENITAL-SKIN FISTUL, FEM	56
6198	FEM GENITAL FISTULA NEC	56
6199	FEM GENITAL FISTULA NOS	56
6200	FOLLICULAR CYST OF OVARY	56
6201	CORPUS LUTEUM CYST	56
6202	OVARIAN CYST NEC/NOS	56
6203	ACQ ATROPHY OVARY & TUBE	56
6204	PROLAPSE OF OVARY & TUBE	56
6205	TORSION OF OVARY OR TUBE	56
6206	BROAD LIGAMENT LACER SYN	56
6207	BROAD LIGAMENT HEMATOMA	56
6208	NONINFL DIS OVA/ADNX NEC	56
6209	NONINFL DIS OVA/ADNX NOS	56
6210	POLYP OF CORPUS UTERI	56
6211	CHR UTERINE SUBINVOLUTN	56
6212	HYPERTROPHY OF UTERUS	56
6213	ENDOMETRIAL HYPERPLASIA	56
6214	HEMATOMETRA	56
6215	INTRAUTERINE SYNECHIAE	56
6216	MALPOSITION OF UTERUS	56
6217	CHR INVERSION OF UTERUS	56
6218	DISORDERS OF UTERUS NEC	56
6219	DISORDER OF UTERUS NOS	56
6220	EROSION/ECTROPION CERVIX	56
6221	DYSPLASIA OF CERVIX	56
6222	LEUKOPLAKIA OF CERVIX	56
6223	OLD LACERATION OF CERVIX	56
6224	STRICTURE OF CERVIX	56
6225	INCOMPETENCE OF CERVIX	56
6226	HYPERTROPHIC ELONG CERVX	56
6227	MUCOUS POLYP OF CERVIX	56
6228	NONINFLAM DIS CERVIX NEC	56
6229	NONINFLAM DIS CERVIX NOS	56
6230	DYSPLASIA OF VAGINA	56
6231	LEUKOPLAKIA OF VAGINA	56
6232	STRICTURE OF VAGINA	56

*ICD–9 Codes preceded by an asterisk are codes that are not valid as a reason for the visit.

ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
6233	TIGHT HYMENAL RING	56
6234	OLD VAGINAL LACERATION	56
6235	NONINFECT VAG LEUKORRHEA	56
6236	VAGINAL HEMATOMA	56
6237	POLYP OF VAGINA	56
6238	NONINFLAM DIS VAGINA NEC	56
6239	NONINFLAM DIS VAGINA NOS	56
6240	DYSTROPHY OF VULVA	56
6241	ATROPHY OF VULVA	56
6242	HYPERTROPHY OF CLITORIS	56
6243	HYPERTROPHY OF LABIA	56
6244	OLD LACERATION OF VULVA	56
6245	HEMATOMA OF VULVA	56
6246	POLYP OF LABIA AND VULVA	56
6248	NONINFLAM DIS VULVA NEC	56
6249	NONINFLAM DIS VULVA NOS	56
6250	DYSPAREUNIA	56
6251	VAGINISMUS	56
6252	MITTELSCHMERZ	56
6253	DYSMENORRHEA	56
6254	PREMENSTRUAL TENSION	56
6255	PELVIC CONGESTION SYND	56
6256	FEM STRESS INCONTINENCE	56
6258	FEM GENITAL SYMPTOMS NEC	56
6259	FEM GENITAL SYMPTOMS NOS	56
6260	ABSENCE OF MENSTRUATION	56
6261	SCANTY MENSTRUATION	56
6262	EXCESSIVE MENSTRUATION	56
6263	PUBERTAL MENORRHAGIA	56
6264	IRREGULAR MENSTRUATION	56
6265	OVULATION BLEEDING	56
6266	METRORRHAGIA	56
6267	POSTCOITAL BLEEDING	56
6268	MENSTRUAL DISORDER NEC	56
6269	MENSTRUAL DISORDER NOS	56
6270	PREMENOPAUSE MENORRHAGIA	56
6271	POSTMENOPAUSAL BLEEDING	56
6272	FEMALE CLIMACTERIC STATE	56
6273	ATROPHIC VAGINITIS	56
6274	ARTIFIC MENOPAUSE STATES	56
6278	MENOPAUSAL DISORDER NEC	56
6279	MENOPAUSAL DISORDER NOS	56
6280	INFERTILITY-ANOVULATION	56
6281	INFERTIL-PITUITARY ORIG	56
6282	INFERTILITY-TUBAL ORIGIN	56
6283	INFERTILITY-UTERINE ORIG	56
6284	INFERTIL-CERVICAL ORIG	56
6288	FEMALE INFERTILITY NEC	56
6289	FEMALE INFERTILITY NOS	56
6290	HEMATOCELE, FEMALE NEC	56
6291	HYDROCELE CANAL NUCK-FEM	56
6298	FEMALE GENITAL DIS NEC	56
6299	FEMALE GENITAL DIS NOS	56
630	HYDATIDIFORM MOLE	57
631	OTH ABN PROD CONCEPTION	57
632	MISSED ABORTION	57
6330	ABDOMINAL PREGNANCY	57
6331	TUBAL PREGNANCY	57
6332	OVARIAN PREGNANCY	57
6338	ECTOPIC PREGNANCY NEC	57
6339	ECTOPIC PREGNANCY NOS	57
63400	SPON ABOR W PEL INF-UNSP	57
63401	SPON ABOR W PELV INF-INC	57
63402	SPON ABOR W PEL INF-COMP	57
63410	SPON ABORT W HEMORR-UNSP	57
63411	SPON ABORT W HEMORR-INC	57
63412	SPON ABORT W HEMORR-COMP	57
63420	SPON AB W PEL DAMAG-UNSP	57
63421	SPON AB W PELV DAMAG-INC	57
63422	SPON AB W PEL DAMAG-COMP	57
63430	SPON AB W REN FAIL-UNSP	57
63431	SPON AB W REN FAIL-INC	57
63432	SPON AB W REN FAIL-COMP	57
63440	SPON AB W METAB DIS-UNSP	57
63441	SPON AB W METAB DIS-INC	57
63442	SPON AB W METAB DIS-COMP	57

*ICD–9 Codes preceded by an asterisk are codes that are not valid as a reason for the visit.

ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
63450	SPON ABORT W SHOCK-UNSP	57
63451	SPON ABORT W SHOCK-INC	57
63452	SPON ABORT W SHOCK-COMP	57
63460	SPON ABORT W EMBOL-UNSP	57
63461	SPON ABORT W EMBOL-INC	57
63462	SPON ABORT W EMBOL-COMP	57
63470	SPON AB W COMPL NEC-UNSP	57
63471	SPON AB W COMPL NEC-INC	57
63472	SPON AB W COMPL NEC-COMP	57
63480	SPON AB W COMPL NOS-UNSP	57
63481	SPON AB W COMPL NOS-INC	57
63482	SPON AB W COMPL NOS-COMP	57
63490	SPON ABORT UNCOMPL-UNSP	57
63491	SPON ABORT UNCOMPL-INC	57
63492	SPON ABORT UNCOMPL-COMP	57
63500	LEG ABOR W PELV INF-UNSP	57
63501	LEG ABOR W PELV INF-INC	57
63502	LEG ABOR W PELV INF-COMP	57
63510	LEGAL ABOR W HEMORR-UNSP	57
63511	LEGAL ABORT W HEMORR-INC	57
63512	LEGAL ABOR W HEMORR-COMP	57
63520	LEG AB W PELV DAMAG-UNSP	57
63521	LEG AB W PELV DAMAG-INC	57
63522	LEG AB W PELV DAMAG-COMP	57
63530	LEG ABOR W REN FAIL-UNSP	57
63531	LEG ABOR W REN FAIL-INC	57
63532	LEG ABOR W REN FAIL-COMP	57
63540	LEG AB W METAB DIS-UNSP	57
63541	LEG AB W METAB DIS-INC	57
63542	LEG AB W METAB DIS-COMP	57
63550	LEGAL ABORT W SHOCK-UNSP	57
63551	LEGAL ABORT W SHOCK-INC	57
63552	LEGAL ABORT W SHOCK-COMP	57
63560	LEGAL ABORT W EMBOL-UNSP	57
63561	LEGAL ABORT W EMBOL-INC	57
63562	LEGAL ABORT W EMBOL-COMP	57
63570	LEG AB W COMPL NEC-UNSP	57
63571	LEG AB W COMPL NEC-INC	57
63572	LEG AB W COMPL NEC-COMP	57
63580	LEG AB W COMPL NOS-UNSP	57
63581	LEG AB W COMPL NOS-INC	57
63582	LEG AB W COMPL NOS-COMP	57
63590	LEGAL ABORT UNCOMPL-UNSP	57
63591	LEGAL ABORT UNCOMPL-INC	57
63592	LEGAL ABORT UNCOMPL-COMP	57
63600	ILLEG AB W PELV INF-UNSP	57
63601	ILLEG AB W PELV INF-INC	57
63602	ILLEG AB W PELV INF-COMP	57
63610	ILLEG AB W HEMORR-UNSPEC	57
63611	ILLEG AB W HEMORR-INC	57
63612	ILLEG AB W HEMORR-COMP	57
63620	ILLEG AB W PEL DAMG-UNSP	57
63621	ILLEG AB W PEL DAMAG-INC	57
63622	ILLEG AB W PEL DAMG-COMP	57
63630	ILLEG AB W REN FAIL-UNSP	57
63631	ILLEG AB W REN FAIL-INC	57
63632	ILLEG AB W REN FAIL-COMP	57
63640	ILLEG AB W MET DIS-UNSP	57
63641	ILLEG AB W METAB DIS-INC	57
63642	ILLEG AB W MET DIS-COMP	57
63650	ILLEG ABORT W SHOCK-UNSP	57
63651	ILLEG ABORT W SHOCK-INC	57
63652	ILLEG ABORT W SHOCK-COMP	57
63660	ILLEG AB W EMBOLISM-UNSP	57
63661	ILLEG AB W EMBOLISM-INC	57
63662	ILLEG AB W EMBOLISM-COMP	57
63670	ILLG AB W COMPL NEC-UNSP	57
63671	ILLEG AB W COMPL NEC-INC	57
63672	ILLG AB W COMPL NEC-COMP	57
63680	ILLG AB W COMPL NOS-UNSP	57
63681	ILLEG AB W COMPL NOS-INC	57
63682	ILLG AB W COMPL NOS-COMP	57
63690	ILLEG ABORT UNCOMPL-UNSP	57
63691	ILLEG ABORT UNCOMPL-INC	57
63692	ILLEG ABORT UNCOMPL-COMP	57
63700	ABORT NOS W PEL INF-UNSP	57

*ICD–9 Codes preceded by an asterisk are codes that are not valid as a reason for the visit.

ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
63701	ABORT NOS W PEL INF-INC	57
63702	ABORT NOS W PEL INF-COMP	57
63710	ABORT NOS W HEMORR-UNSP	57
63711	ABORT NOS W HEMORR-INC	57
63712	ABORT NOS W HEMORR-COMP	57
63720	AB NOS W PELV DAMAG-UNSP	57
63721	AB NOS W PELV DAMAG-INC	57
63722	AB NOS W PELV DAMAG-COMP	57
63730	AB NOS W RENAL FAIL-UNSP	57
63731	AB NOS W RENAL FAIL-INC	57
63732	AB NOS W RENAL FAIL-COMP	57
63740	AB NOS W METAB DIS-UNSP	57
63741	AB NOS W METAB DIS-INC	57
63742	AB NOS W METAB DIS-COMP	57
63750	ABORT NOS W SHOCK-UNSP	57
63751	ABORT NOS W SHOCK-INC	57
63752	ABORT NOS W SHOCK-COMP	57
63760	AB NOS W EMBOLISM-UNSP	57
63761	AB NOS W EMBOLISM-INC	57
63762	AB NOS W EMBOLISM-COMP	57
63770	AB NOS W COMPL NEC-UNSP	57
63771	AB NOS W COMPL NEC-INC	57
63772	AB NOS W COMPL NEC-COMP	57
63780	AB NOS W COMPL NOS-UNSP	57
63781	AB NOS W COMPL NOS-INC	57
63782	AB NOS W COMPL NOS-COMP	57
63790	AB NOS UNCOMPLICAT-UNSP	57
63791	AB NOS UNCOMPLICAT-INC	57
63792	AB NOS UNCOMPLICAT-COMP	57
6380	ATTEM ABORT W PELVIC INF	57
6381	ATTEM ABORT W HEMORRHAGE	57
6382	ATTEM ABORT W PELV DAMAG	57
6383	ATTEM ABORT W RENAL FAIL	57
6384	ATTEM ABOR W METABOL DIS	57
6385	ATTEM ABORTION W SHOCK	57
6386	ATTEMP ABORT W EMBOLISM	57
6387	ATTEMP ABORT W COMPL NEC	57
6388	ATTEMP ABORT W COMPL NOS	57
6389	ATTEMPTED ABORT UNCOMPL	57
6390	POSTABORTION GU INFECT	57
6391	POSTABORTION HEMORRHAGE	57
6392	POSTABORT PELVIC DAMAGE	57
6393	POSTABORT RENAL FAILURE	57
6394	POSTABORT METABOLIC DIS	57
6395	POSTABORTION SHOCK	57
6396	POSTABORTION EMBOLISM	57
6398	POSTABORTION COMPL NEC	57
6399	POSTABORTION COMPL NOS	57
64000	THREATENED ABORT-UNSPEC	57
*64001	THREATENED ABORT-DELIVER	
64003	THREATEN ABORT-ANTEPART	57
64080	HEM EARLY PREG NEC-UNSP	57
*64081	HEM EARLY PREG NEC-DELIV	
64083	HEM EARLY PG NEC-ANTEPAR	57
64090	HEMORR EARLY PREG-UNSPEC	57
*64091	HEM EARLY PREG-DELIVERED	
64093	HEM EARLY PREG-ANTEPART	57
64100	PLACENTA PREVIA-UNSPEC	57
*64101	PLACENTA PREVIA-DELIVER	
64103	PLACENTA PREVIA-ANTEPART	57
64110	PLACENTA PREV HEM-UNSPEC	57
*64111	PLACENTA PREV HEM-DELIV	
64113	PLACEN PREV HEM-ANTEPART	57
64120	PREM SEPAR PLACEN-UNSPEC	57
64121	PREM SEPAR PLACEN-DELIV	57
64123	PREM SEPAR PLAC-ANTEPART	57
64130	COAG DEF HEMORR-UNSPEC	57
64131	COAG DEF HEMORR-DELIVER	57
64133	COAG DEF HEMORR-ANTEPART	57
64180	ANTEPART HEM NEC-UNSPEC	57
*64181	ANTEPARTUM HEM NEC-DELIV	
64183	ANTEPART HEM NEC-ANTEPAR	57
64190	ANTEPART HEM NOS-UNSPEC	57
*64191	ANTEPARTUM HEM NOS-DELIV	
64193	ANTEPART HEM NOS-ANTEPAR	57
64200	ESSEN HYPERTEN PREG-UNSP	57

*ICD–9 Codes preceded by an asterisk are codes that are not valid as a reason for the visit.

ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
*64201	ESSEN HYPERTEN-DELIVERED	
*64202	ESSEN HYPERTEN-DEL W P/P	
64203	ESSEN HYPERTEN-ANTEPART	57
64204	ESSEN HYPERTEN-POSTPART	57
64210	RENAL HYPERTEN PREG-UNSP	57
*64211	RENAL HYPERTEN PG-DELIV	
*64212	RENAL HYPERTEN-DEL P/P	
64213	RENAL HYPERTEN-ANTEPART	57
64214	RENAL HYPERTEN-POSTPART	57
64220	OLD HYPERTEN PREG-UNSPEC	57
*64221	OLD HYPERTEN NEC-DELIVER	
*64222	OLD HYPERTEN-DELIV W P/P	
64223	OLD HYPERTEN NEC-ANTEPAR	57
64224	OLD HYPERTEN NEC-POSTPAR	57
64230	TRANS HYPERTEN PREG-UNSP	57
*64231	TRANS HYPERTEN-DELIVERED	
*64232	TRANS HYPERTEN-DEL W P/P	
64233	TRANS HYPERTEN-ANTEPART	57
64234	TRANS HYPERTEN-POSTPART	57
64240	MILD/NOS PREECLAMP-UNSP	57
*64241	MILD/NOS PREECLAMP-DELIV	
*64242	MILD PREECLAMP-DEL W P/P	
64243	MILD/NOS PREECLAMP-ANTEP	57
64244	MILD/NOS PREECLAMP-P/P	57
64250	SEVERE PREECLAMP-UNSPEC	57
*64251	SEVERE PREECLAMP-DELIVER	
*64252	SEV PREECLAMP-DEL W P/P	
64253	SEV PREECLAMP-ANTEPARTUM	57
64254	SEV PREECLAMP-POSTPARTUM	57
64260	ECLAMPSIA-UNSPECIFIED	57
*64261	ECLAMPSIA-DELIVERED	
*64262	ECLAMPSIA-DELIV W P/P	
64263	ECLAMPSIA-ANTEPARTUM	57
64264	ECLAMPSIA-POSTPARTUM	57
64270	TOX W OLD HYPERTEN-UNSP	57
*64271	TOX W OLD HYPERTEN-DELIV	
*64272	TOX W OLD HYP-DEL W P/P	
64273	TOX W OLD HYPER-ANTEPART	57
64274	TOX W OLD HYPER-POSTPART	57
64290	HYPERTEN PREG NOS-UNSPEC	57
*64291	HYPERTENS NOS-DELIVERED	
*64292	HYPERTENS NOS-DEL W P/P	
64293	HYPERTENS NOS-ANTEPARTUM	57
64294	HYPERTENS NOS-POSTPARTUM	57
64300	MILD HYPEREM GRAV-UNSPEC	57
*64301	MILD HYPEREM GRAV-DELIV	
64303	MILD HYPEREMESIS-ANTEPAR	57
64310	HYPEREM W METAB DIS-UNSP	57
*64311	HYPEREM W METAB DIS-DEL	
64313	HYPEREM W METAB-ANTEPART	57
64320	LATE VOMIT OF PREG-UNSP	57
*64321	LATE VOMIT OF PREG-DELIV	
64323	LATE VOMIT PREG-ANTEPART	57
64380	VOMIT COMPL PREG-UNSPEC	57
*64381	VOMIT COMPL PREG-DELIVER	
*64383	VOMIT COMPL PREG-ANTEPAR	57
64390	VOMIT OF PREG NOS-UNSPEC	57
*64391	VOMIT OF PREG NOS-DELIV	
*64393	VOMIT OF PG NOS-ANTEPART	57
64400	THREAT PREM LABOR-UNSPEC	57
64403	THRT PREM LABOR-ANTEPART	57
*64410	THREAT LABOR NEC-UNSPEC	57
64413	THREAT LABOR NEC-ANTEPAR	57
64420	EARLY ONSET DELIV-UNSPEC	57
*64421	EARLY ONSET DELIVERY-DEL	
64500	PROLONGED PREG-UNSPEC	57
*64501	PROLONGED PREG-DELIVERED	
64503	PROLONGED PREG-ANTEPART	57
64600	PAPYRACEOUS FETUS-UNSPEC	57
*64601	PAPYRACEOUS FETUS-DELIV	
64603	PAPYRACEOUS FET-ANTEPAR	57
64610	EDEMA IN PREG-UNSPEC	57
*64611	EDEMA IN PREG-DELIVERED	
*64612	EDEMA IN PREG-DEL W P/P	
64613	EDEMA IN PREG-ANTEPARTUM	57
64614	EDEMA IN PREG-POSTPARTUM	57

*ICD–9 Codes preceded by an asterisk are codes that are not valid as a reason for the visit.

ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
64620	RENAL DIS PREG NOS-UNSP	57
*64621	RENAL DIS NOS-DELIVERED	
*64622	RENAL DIS NOS-DEL W P/P	
*64623	RENAL DIS NOS-ANTEPARTUM	57
64624	RENAL DIS NOS-POSTPARTUM	57
64630	HABITUAL ABORTER-UNSPEC	57
*64631	HABITUAL ABORTER-DELIVER	
64633	HABITUAL ABORT-ANTEPART	57
64640	NEURITIS OF PREG-UNSPEC	57
*64641	NEURITIS-DELIVERED	
*64642	NEURITIS-DELIVERED W P/P	
64643	NEURITIS OF PREG-ANTEPAR	57
64644	NEURITIS OF PREG-POSTPAR	57
64650	BACTERIURIA PREG-UNSPEC	57
*64651	ASYM BACTERIURIA-DELIVER	
*64652	ASY BACTERURIA-DEL W P/P	
64653	ASY BACTERIURIA-ANTEPART	57
64654	ASY BACTERIURIA-POSTPART	57
64660	GU INFECT IN PREG-UNSPEC	57
*64661	GU INFECTION-DELIVERED	
*64662	GU INFECTION-DELIV W P/P	
64663	GU INFECTION-ANTEPARTUM	57
64664	GU INFECTION-POSTPARTUM	57
64670	LIVER DIS IN PREG-UNSPEC	57
*64671	LIVER DISORDER-DELIVERED	
64673	LIVER DISORDER-ANTEPART	57
64680	PREG COMPL NEC-UNSPEC	57
*64681	PREG COMPL NEC-DELIVERED	
*64682	PREG COMPL NEC-DEL W P/P	
64683	PREG COMPL NEC-ANTEPART	57
64684	PREG COMPL NEC-POSTPART	57
64690	PREG COMPL NOS-UNSPEC	57
*64691	PREG COMPL NOS-DELIVERED	
64693	PREG COMPL NOS-ANTEPART	57
64700	SYPHILIS IN PREG-UNSPEC	57
*64701	SYPHILIS-DELIVERED	
*64702	SYPHILIS-DELIVERED W P/P	
64703	SYPHILIS-ANTEPARTUM	57
64704	SYPHILIS-POSTPARTUM	57
64710	GONORRHEA IN PREG-UNSPEC	57
*64711	GONORRHEA-DELIVERED	
*64712	GONORRHEA-DELIVER W P/P	
64713	GONORRHEA-ANTEPARTUM	57
64714	GONORRHEA-POSTPARTUM	57
64720	OTHER VD IN PREG-UNSPEC	57
*64721	OTHER VD-DELIVERED	
*64722	OTHER VD-DELIVERED W P/P	
64723	OTHER VD-ANTEPARTUM	57
64724	OTHER VD-POSTPARTUM	57
64730	TB IN PREG-UNSPECIFIED	57
*64731	TUBERCULOSIS-DELIVERED	
*64732	TUBERCULOSIS-DELIV W P/P	
64733	TUBERCULOSIS-ANTEPARTUM	57
64734	TUBERCULOSIS-POSTPARTUM	57
64740	MALARIA IN PREG-UNSPEC	57
*64741	MALARIA-DELIVERED	
*64742	MALARIA-DELIVERED W P/P	
64743	MALARIA-ANTEPARTUM	57
64744	MALARIA-POSTPARTUM	57
64750	RUBELLA IN PREG-UNSPEC	57
*64751	RUBELLA-DELIVERED	
*64752	RUBELLA-DELIVERED W P/P	
64753	RUBELLA-ANTEPARTUM	57
64754	RUBELLA-POSTPARTUM	57
64760	OTH VIRUS IN PREG-UNSPEC	57
*64761	OTH VIRAL DIS-DELIVERED	
*64762	OTH VIRAL DIS-DEL W P/P	
64763	OTH VIRAL DIS-ANTEPARTUM	57
64764	OTH VIRAL DIS-POSTPARTUM	57
64780	INF DIS IN PREG NEC-UNSP	57
*64781	INFECT DIS NEC-DELIVERED	
*64782	INFECT DIS NEC-DEL W P/P	
64783	INFECT DIS NEC-ANTEPART	57
64784	INFECT DIS NEC-POSTPART	57
64790	INFECT IN PREG NOS-UNSP	57
*64791	INFECT NOS-DELIVERED	

*ICD–9 Codes preceded by an asterisk are codes that are not valid as a reason for the visit.

ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
*64792	INFECT NOS-DELIVER W P/P	
64793	INFECT NOS-ANTEPARTUM	57
64794	INFECT NOS-POSTPARTUM	57
64800	DIABETES IN PREG-UNSPEC	57
*64801	DIABETES-DELIVERED	
*64802	DIABETES-DELIVERED W P/P	
64803	DIABETES-ANTEPARTUM	57
64804	DIABETES-POSTPARTUM	57
64810	THYROID DYSFUN PREG-UNSP	57
*64811	THYROID DYSFUNC-DELIVER	
*64812	THYROID DYSFUN-DEL W P/P	
64813	THYROID DYSFUNC-ANTEPART	57
64814	THYROID DYSFUNC-POSTPART	57
64820	ANEMIA IN PREG-UNSPEC	57
*64821	ANEMIA-DELIVERED	
*64822	ANEMIA-DELIVERED W P/P	
64823	ANEMIA-ANTEPARTUM	57
64824	ANEMIA-POSTPARTUM	57
64830	DRUG DEPEND PREG-UNSPEC	57
*64831	DRUG DEPENDENCE-DELIVER	
*64832	DRUG DEPENDEN-DEL W P/P	
64833	DRUG DEPENDENCE-ANTEPART	57
64834	DRUG DEPENDENCE-POSTPART	57
64840	MENTAL DIS PREG-UNSPEC	57
*64841	MENTAL DISORDER-DELIVER	
*64842	MENTAL DIS-DELIV W P/P	
64843	MENTAL DISORDER-ANTEPART	57
64844	MENTAL DISORDER-POSTPART	57
64850	CONGEN CV DIS PREG-UNSP	57
*64851	CONGEN CV DIS-DELIVERED	
*64852	CONGEN CV DIS-DEL W P/P	
64853	CONGEN CV DIS-ANTEPARTUM	57
64854	CONGEN CV DIS-POSTPARTUM	57
64860	CV DIS NEC PREG-UNSPEC	57
*64861	CV DIS NEC PREG-DELIVER	
*64862	CV DIS NEC-DELIVER W P/P	
64863	CV DIS NEC-ANTEPARTUM	57
64864	CV DIS NEC-POSTPARTUM	57
64870	BONE DISORD IN PREG-UNSP	57
*64871	BONE DISORDER-DELIVERED	
*64872	BONE DISORDER-DEL W P/P	
64873	BONE DISORDER-ANTEPARTUM	57
64874	BONE DISORDER-POSTPARTUM	57
64880	ABN GLUCOSE IN PREG-UNSP	57
*64881	ABN GLUCOSE TOLER-DELIV	
*64882	ABN GLUCOSE-DELIV W P/P	
64883	ABN GLUCOSE-ANTEPARTUM	57
64884	ABN GLUCOSE-POSTPARTUM	57
64890	OTH CURR COND PREG-UNSP	57
*64891	OTH CURR COND-DELIVERED	
*64892	OTH CURR COND-DEL W P/P	
64893	OTH CURR COND-ANTEPARTUM	57
64894	OTH CURR COND-POSTPARTUM	57
*650	NORMAL DELIVERY	
65100	TWIN PREGNANCY-UNSPEC	57
*65101	TWIN PREGNANCY-DELIVERED	
65103	TWIN PREGNANCY-ANTEPART	57
65110	TRIPLET PREGNANCY-UNSPEC	57
*65111	TRIPLET PREGNANCY-DELIV	
65113	TRIPLET PREG-ANTEPARTUM	57
65120	QUADRUPLET PREG-UNSPEC	57
*65121	QUADRUPLET PREG-DELIVER	
65123	QUADRUPLET PREG-ANTEPART	57
65130	TWINS W FETAL LOSS-UNSP	57
*65131	TWINS W FETAL LOSS-DEL	
65133	TWINS W FETAL LOSS-ANTE	57
65140	TRIPLETS W FET LOSS-UNSP	57
*65141	TRIPLETS W FET LOSS-DEL	
65143	TRIPLETS W FET LOSS-ANTE	57
65150	QUADS W FETAL LOSS-UNSP	57
*65151	QUADS W FETAL LOSS-DEL	
65153	QUADS W FETAL LOSS-ANTE	57
65160	MULT GES W FET LOSS-UNSP	57
*65161	MULT GES W FET LOSS-DEL	
65163	MULT GES W FET LOSS-ANTE	57
65180	MULTI GESTAT NEC-UNSPEC	57

*ICD–9 Codes preceded by an asterisk are codes that are not valid as a reason for the visit.

ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
*65181	MULTI GESTAT NEC-DELIVER	
65183	MULTI GEST NEC-ANTEPART	57
65190	MULTI GESTAT NOS-UNSPEC	57
*65191	MULT GESTATION NOS-DELIV	
65193	MULTI GEST NOS-ANTEPART	57
65200	UNSTABLE LIE-UNSPECIFIED	57
*65201	UNSTABLE LIE-DELIVERED	
65203	UNSTABLE LIE-ANTEPARTUM	57
65210	CEPHALIC VERS NOS-UNSPEC	57
*65211	CEPHALIC VERS NOS-DELIV	
65213	CEPHAL VERS NOS-ANTEPART	57
65220	BREECH PRESENTAT-UNSPEC	57
*65221	BREECH PRESENTAT-DELIVER	
65223	BREECH PRESENT-ANTEPART	57
65230	TRANSV/OBLIQ LIE-UNSPEC	57
*65231	TRANSVER/OBLIQ LIE-DELIV	
65233	TRANSV/OBLIQ LIE-ANTEPAR	57
65240	FACE/BROW PRESENT-UNSPEC	57
*65241	FACE/BROW PRESENT-DELIV	
65243	FACE/BROW PRES-ANTEPART	57
65250	HIGH HEAD AT TERM-UNSPEC	57
*65251	HIGH HEAD AT TERM-DELIV	
65253	HIGH HEAD TERM-ANTEPART	57
65260	MULT GEST MALPRESEN-UNSP	57
*65261	MULT GEST MALPRES-DELIV	
65263	MULT GES MALPRES-ANTEPAR	57
65270	PROLAPSED ARM-UNSPEC	57
*65271	PROLAPSED ARM-DELIVERED	
65273	PROLAPSED ARM-ANTEPART	57
65280	MALPOSITION NEC-UNSPEC	57
*65281	MALPOSITION NEC-DELIVER	
65283	MALPOSITION NEC-ANTEPART	57
65290	MALPOSITION NOS-UNSPEC	57
*65291	MALPOSITION NOS-DELIVER	
65293	MALPOSITION NOS-ANTEPART	57
65300	PELVIC DEFORM NOS-UNSPEC	57
*65301	PELVIC DEFORM NOS-DELIV	
65303	PELV DEFORM NOS-ANTEPART	57
65310	CONTRACT PELV NOS-UNSPEC	57
*65311	CONTRACT PELV NOS-DELIV	
65313	CONTRAC PELV NOS-ANTEPAR	57
65320	INLET CONTRACTION-UNSPEC	57
*65321	INLET CONTRACTION-DELIV	
65323	INLET CONTRACT-ANTEPART	57
65330	OUTLET CONTRACTION-UNSP	57
*65331	OUTLET CONTRACTION-DELIV	
65333	OUTLET CONTRACT-ANTEPART	57
65340	FETOPELV DISPROP-UNSPEC	57
*65341	FETOPELV DISPROPOR-DELIV	
65343	FETOPEL DISPROP-ANTEPART	57
65350	FETAL DISPROP NOS-UNSPEC	57
*65351	FETAL DISPROP NOS-DELIV	
65353	FETAL DISPRO NOS-ANTEPAR	57
65360	HYDROCEPHAL FETUS-UNSPEC	57
*65361	HYDROCEPH FETUS-DELIVER	
65363	HYDROCEPH FETUS-ANTEPART	57
65370	OTH ABN FET DISPROP-UNSP	57
*65371	OTH ABN FET DISPRO-DELIV	
65373	OTH ABN FET DISPRO-ANTEP	57
65380	DISPROPORTION NEC-UNSPEC	57
*65381	DISPROPORTION NEC-DELIV	
65383	DISPROPOR NEC-ANTEPARTUM	57
*65390	DISPROPORTION NOS-UNSPEC	
*65391	DISPROPORTION NOS-DELIV	
65393	DISPROPOR NOS-ANTEPARTUM	57
65400	CONG ABN UTER PREG-UNSP	57
*65401	CONGEN ABN UTERUS-DELIV	
*65402	CONG ABN UTER-DEL W P/P	
65403	CONGEN ABN UTER-ANTEPART	57
65404	CONGEN ABN UTER-POSTPART	57
65410	UTER TUMOR IN PREG-UNSP	57
*65411	UTERINE TUMOR-DELIVERED	
*65412	UTERINE TUMOR-DEL W P/P	
65413	UTERINE TUMOR-ANTEPARTUM	57
65414	UTERINE TUMOR-POSTPARTUM	57
65420	PREV C-DELIVERY UNSPEC	57

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
*65421	PREV C-DELIVERY-DELIVRD	
65423	PREV C-DELIVERY-ANTEPART	57
65430	RETROVERT UTERUS-UNSPEC	57
*65431	RETROVERT UTERUS-DELIVER	
*65432	RETROVERT UTER-DEL W P/P	
65433	RETROVERT UTER-ANTEPART	57
65434	RETROVERT UTER-POSTPART	57
65440	ABN GRAV UTERUS NEC-UNSP	57
*65441	ABN UTERUS NEC-DELIVERED	
*65442	ABN UTERUS NEC-DEL W P/P	
65443	ABN UTERUS NEC-ANTEPART	57
65444	ABN UTERUS NEC-POSTPART	57
65450	CERV INCOMPET PREG-UNSP	57
*65451	CERVICAL INCOMPET-DELIV	
*65452	CERV INCOMPET-DEL W P/P	
65453	CERV INCOMPET-ANTEPARTUM	57
65454	CERV INCOMPET-POSTPARTUM	57
65460	ABN CERVIX NEC PREG-UNSP	57
*65461	ABN CERVIX NEC-DELIVERED	
*65462	ABN CERVIX NEC-DEL W P/P	
65463	ABN CERVIX NEC-ANTEPART	57
65464	ABN CERVIX NEC-POSTPART	57
65470	ABN VAGINA IN PREG-UNSP	57
*65471	ABNORM VAGINA-DELIVERED	
*65472	ABNORM VAGINA-DEL W P/P	
65473	ABNORM VAGINA-ANTEPARTUM	57
65474	ABNORM VAGINA-POSTPARTUM	57
65480	ABN VULVA IN PREG-UNSPEC	57
*65481	ABNORMAL VULVA-DELIVERED	
*65482	ABNORMAL VULVA-DEL W P/P	
65483	ABNORMAL VULVA-ANTEPART	57
65484	ABNORMAL VULVA-POSTPART	57
65490	ABN PEL NEC IN PREG-UNSP	57
*65491	ABN PELV ORG NEC-DELIVER	
*65492	ABN PELV NEC-DELIV W P/P	
65493	ABN PELV ORG NEC-ANTEPAR	57
65494	ABN PELV ORG NEC-POSTPAR	57
65500	FETAL CNS MALFORM-UNSPEC	57
*65501	FETAL CNS MALFORM-DELIV	
65503	FETAL CNS MALFOR-ANTEPAR	57
65510	FETAL CHROMOS ABN-UNSPEC	57
*65511	FETAL CHROMOSO ABN-DELIV	
65513	FET CHROMO ABN-ANTEPART	57
65520	FAMIL HEREDIT DIS-UNSPEC	57
*65521	FAMIL HEREDIT DIS-DELIV	
65523	FAMIL HERED DIS-ANTEPART	57
65530	FET DAMG D/T VIRUS-UNSP	57
*65531	FET DAMG D/T VIRUS-DELIV	
65533	FET DAMG D/T VIRUS-ANTEP	57
65540	FET DAMG D/T DIS-UNSPEC	57
*65541	FET DAMG D/T DIS-DELIVER	
65543	FET DAMG D/T DIS-ANTEPAR	57
65550	FETAL DAMG D/T DRUG-UNSP	57
*65551	FET DAMAG D/T DRUG-DELIV	
65553	FET DAMG D/T DRUG-ANTEPA	57
65560	RADIAT FETAL DAMAG-UNSP	57
*65561	RADIAT FETAL DAMAG-DELIV	
65563	RADIAT FET DAMAG-ANTEPAR	57
65580	FETAL ABNORM NEC-UNSPEC	57
*65581	FETAL ABNORM NEC-DELIVER	
65583	FETAL ABNORM NEC-ANTEPAR	57
65590	FETAL ABNORM NOS-UNSPEC	57
*65591	FETAL ABNORM NOS-DELIVER	
65593	FETAL ABNORM NOS-ANTEPAR	57
65600	FETAL-MATERNAL HEM-UNSP	57
*65601	FETAL-MATERNAL HEM-DELIV	
65603	FETAL-MATERN HEM-ANTEPAR	57
65610	RH ISOIMMUNIZATION-UNSP	57
*65611	RH ISOIMMUNIZAT-DELIVER	
65613	RH ISOIMMUNIZAT-ANTEPART	57
65620	ABO ISOIMMUNIZATION-UNSP	57
*65621	ABO ISOIMMUNIZAT-DELIVER	
65623	ABO ISOIMMUNIZAT-ANTEPAR	57
65630	FETAL DISTRESS-UNSPEC	57
*65631	FETAL DISTRESS-DELIVERED	
65633	FETAL DISTRESS-ANTEPART	57

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
65640	INTRAUTERINE DEATH-UNSP	57
*65641	INTRAUTER DEATH-DELIVER	
65643	INTRAUTER DEATH-ANTEPART	57
65650	POOR FETAL GROWTH-UNSPEC	57
*65651	POOR FETAL GROWTH-DELIV	
65653	POOR FETAL GRTH-ANTEPART	57
65660	EXCESS FETAL GRTH-UNSPEC	57
*65661	EXCESS FETAL GRTH-DELIV	
65663	EXCESS FET GRTH-ANTEPART	57
65670	OTH PLACENT COND-UNSPEC	57
*65671	OTH PLACENT COND-DELIVER	
65673	OTH PLACENT COND-ANTEPAR	57
65680	FET/PLAC PROB NEC-UNSPEC	57
*65681	FET/PLAC PROB NEC-DELIV	
65683	FET/PLAC PROB NEC-ANTEPA	57
65690	FET/PLAC PROB NOS-UNSPEC	57
*65691	FET/PLAC PROB NOS-DELIV	
65693	FET/PLAC PROB NOS-ANTEPA	57
65700	POLYHYDRAMNIOS-UNSPEC	57
*65701	POLYHYDRAMNIOS-DELIVERED	
65703	POLYHYDRAMNIOS-ANTEPART	57
65800	OLIGOHYDRAMNIOS-UNSPEC	57
*65801	OLIGOHYDRAMNIOS-DELIVER	
65803	OLIGOHYDRAMNIOS-ANTEPAR	57
65810	PREM RUPT MEMBRAN-UNSPEC	57
*65811	PREM RUPT MEMBRAN-DELIV	
65813	PREM RUPT MEMB-ANTEPART	57
65820	PROLONG RUPT MEMB-UNSPEC	57
65821	PROLONG RUPT MEMB-DELIV	57
65823	PROLONG RUP MEMB-ANTEPAR	57
65830	ARTIFIC RUPT MEMBR-UNSP	57
*65831	ARTIFIC RUPT MEMBR-DELIV	
65833	ARTIF RUPT MEMB-ANTEPART	57
65840	AMNIOTIC INFECTION-UNSP	57
*65841	AMNIOTIC INFECTION-DELIV	
65843	AMNIOTIC INFECT-ANTEPART	57
65880	AMNIOTIC PROB NEC-UNSPEC	57
*65881	AMNIOTIC PROB NEC-DELIV	
65883	AMNION PROB NEC-ANTEPART	57
65890	AMNIOTIC PROB NOS-UNSPEC	57
65891	AMNIOTIC PROB NOS-DELIV	57
65893	AMNION PROB NOS-ANTEPART	57
65900	FAIL MECHAN INDUCT-UNSP	57
*65901	FAIL MECH INDUCT-DELIVER	
65903	FAIL MECH INDUCT-ANTEPAR	57
65910	FAIL INDUCTION NOS-UNSP	57
*65911	FAIL INDUCTION NOS-DELIV	
65913	FAIL INDUCT NOS-ANTEPART	57
65920	PYREXIA IN LABOR-UNSPEC	57
*65921	PYREXIA IN LABOR-DELIVER	
65923	PYREXIA IN LABOR-ANTEPAR	57
65930	SEPTICEMIA IN LABOR-UNSP	57
*65931	SEPTICEM IN LABOR-DELIV	
65933	SEPTICEM IN LABOR-ANTEPA	57
65940	GRAND MULTIPARITY-UNSPEC	57
*65941	GRAND MULTIPARITY-DELIV	
65943	GRAND MULTIPARITY-ANTEPA	57
65950	ELDERLY PRIMIGRAVID-UNSP	57
*65951	ELDERLY PRIMIGRAVIDA-DEL	
65953	ELDER PRIMIGRAVID-ANTEPA	57
65960	OTH ADVNCD MTRNL AGE UNS	57
*65961	OTH ADVNCD MTRNL AGE DEL	
65963	OTH ADVNCD MTRNL AGE ANT	57
65980	COMPLIC LABOR NEC-UNSP	57
*65981	COMPLIC LABOR NEC-DELIV	
65983	COMPL LABOR NEC-ANTEPART	57
65990	COMPLIC LABOR NOS-UNSP	57
*65991	COMPLIC LABOR NOS-DELIV	
65993	COMPL LABOR NOS-ANTEPART	57
66000	OBSTRUCT/FET MALPOS-UNSP	57
*66001	OBSTRUC/FET MALPOS-DELIV	
66003	OBSTRUC/FET MALPOS-ANTEP	57
66010	BONY PELV OBSTRUC-UNSPEC	57
*66011	BONY PELV OBSTRUCT-DELIV	
66013	BONY PELV OBSTRUC-ANTEPA	57
66020	ABN PELV TISS OBSTR-UNSP	57

*ICD–9 Codes preceded by an asterisk are codes that are not valid as a reason for the visit.

ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
66021	ABN PELV TIS OBSTR-DELIV	57
66023	ABN PELV TIS OBSTR-ANTEP	57
66030	PERSIST OCCIPITPOST-UNSP	57
*66031	PERSIST OCCIPTPOST-DELIV	
66033	PERSIST OCCIPTPOST-ANTEP	57
66040	SHOULDER DYSTOCIA-UNSPEC	57
*66041	SHOULDER DYSTOCIA-DELIV	
66043	SHOULDER DYSTOCIA-ANTEPA	57
66050	LOCKED TWINS-UNSPECIFIED	57
*66051	LOCKED TWINS-DELIVERED	
66053	LOCKED TWINS-ANTEPARTUM	57
66060	FAIL TRIAL LAB NOS-UNSP	57
*66061	FAIL TRIAL LAB NOS-DELIV	
66063	FAIL TRIAL LAB NOS-ANTEP	57
66070	FAILED FORCEP NOS-UNSPEC	57
*66071	FAILED FORCEPS NOS-DELIV	
66073	FAIL FORCEPS NOS-ANTEPAR	57
66080	OBSTRUC LABOR NEC-UNSPEC	57
*66081	OBSTRUCT LABOR NEC-DELIV	
66083	OBSTRUC LABOR NEC-ANTEPA	57
66090	OBSTRUC LABOR NOS-UNSPEC	57
*66091	OBSTRUCT LABOR NOS-DELIV	
66093	OBSTRUC LABOR NOS-ANTEPA	57
66100	PRIM UTERINE INERT-UNSP	57
*66101	PRIM UTERINE INERT-DELIV	
66103	PRIM UTER INERT-ANTEPART	57
66110	SEC UTERINE INERT-UNSPEC	57
*66111	SEC UTERINE INERT-DELIV	
66113	SEC UTERINE INERT-ANTEPA	57
66120	UTERINE INERTIA NEC-UNSP	57
*66121	UTERINE INERT NEC-DELIV	
66123	UTERINE INERT NEC-ANTEPA	57
66130	PRECIPITATE LABOR-UNSPEC	57
*66131	PRECIPITATE LABOR-DELIV	
66133	PRECIPITATE LABOR-ANTEPA	57
66140	UTER DYSTOCIA NOS-UNSPEC	57
*66141	UTER DYSTOCIA NOS-DELIV	
66143	UTER DYSTOCIA NOS-ANTEPA	57
66190	ABNORMAL LABOR NOS-UNSP	57
*66191	ABNORMAL LABOR NOS-DELIV	
66193	ABNORM LABOR NOS-ANTEPAR	57
66200	PROLONGED 1ST STAGE-UNSP	57
*66201	PROLONG 1ST STAGE-DELIV	
66203	PROLONG 1ST STAGE-ANTEPA	57
66210	PROLONGED LABOR NOS-UNSP	57
*66211	PROLONG LABOR NOS-DELIV	
66213	PROLONG LABOR NOS-ANTEPA	57
66220	PROLONGED 2ND STAGE-UNSP	57
*66221	PROLONG 2ND STAGE-DELIV	
66223	PROLONG 2ND STAGE-ANTEPA	57
66230	DELAY DEL 2ND TWIN-UNSP	57
*66231	DELAY DEL 2ND TWIN-DELIV	
66233	DELAY DEL 2 TWIN-ANTEPAR	57
66300	CORD PROLAPSE-UNSPEC	57
*66301	CORD PROLAPSE-DELIVERED	
66303	CORD PROLAPSE-ANTEPARTUM	57
66310	CORD AROUND NECK-UNSPEC	57
*66311	CORD AROUND NECK-DELIVER	
66313	CORD AROUND NECK-ANTEPAR	57
66320	CORD COMPRESS NEC-UNSPEC	57
*66321	CORD COMPRESS NEC-DELIV	
66323	CORD COMPRES NEC-ANTEPAR	57
66330	CORD ENTANGLE NEC-UNSPEC	57
*66331	CORD ENTANGLE NEC-DELIV	
66333	CORD ENTANGL NEC-ANTEPAR	57
66340	SHORT CORD-UNSPECIFIED	57
*66341	SHORT CORD-DELIVERED	
66343	SHORT CORD-ANTEPARTUM	57
66350	VASA PREVIA-UNSPECIFIED	57
*66351	VASA PREVIA-DELIVERED	
66353	VASA PREVIA-ANTEPARTUM	57
66360	VASC LESION CORD-UNSPEC	57
*66361	VASC LESION CORD-DELIVER	
66363	VASC LESION CORD-ANTEPAR	57
66380	CORD COMPLICAT NEC-UNSP	57
*66381	CORD COMPLICAT NEC-DELIV	

*ICD–9 Codes preceded by an asterisk are codes that are not valid as a reason for the visit.

ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
66383	CORD COMPL NEC-ANTEPART	57
66390	CORD COMPLICAT NOS-UNSP	57
*66391	CORD COMPLICAT NOS-DELIV	
66393	CORD COMPL NOS-ANTEPART	57
66400	DEL W 1 DEG LACERAT-UNSP	57
*66401	DEL W 1 DEG LACERAT-DEL	
66404	DEL W 1 DEG LAC-POSTPART	57
66410	DEL W 2 DEG LACERAT-UNSP	57
*66411	DEL W 2 DEG LACERAT-DEL	
66414	DEL W 2 DEG LAC-POSTPART	57
66420	DEL W 3 DEG LACERAT-UNSP	57
*66421	DEL W 3 DEG LACERAT-DEL	
66424	DEL W 3 DEG LAC-POSTPART	57
66430	DEL W 4 DEG LACERAT-UNSP	57
*66431	DEL W 4 DEG LACERAT-DEL	
66434	DEL W 4 DEG LAC-POSTPART	57
66440	OB PERINEAL LAC NOS-UNSP	57
*66441	OB PERINEAL LAC NOS-DEL	
66444	PERINEAL LAC NOS-POSTPAR	57
66450	OB PERINEAL HEMATOM-UNSP	57
*66451	OB PERINEAL HEMATOMA-DEL	
66454	PERIN HEMATOMA-POSTPART	57
66480	OB PERIN TRAUM NEC-UNSP	57
*66481	OB PERINEAL TRAU NEC-DEL	
66484	PERIN TRAUM NEC-POSTPART	57
66490	OB PERIN TRAUM NOS-UNSP	57
*66491	OB PERINEAL TRAU NOS-DEL	
66494	PERIN TRAUM NOS-POSTPART	57
66500	PRELABOR RUPT UTER-UNSP	57
*66501	PRELABOR RUPT UTERUS-DEL	
66503	PRELAB RUPT UTER-ANTEPAR	57
66510	RUPTURE UTERUS NOS-UNSP	57
*66511	RUPTURE UTERUS NOS-DELIV	
66520	INVERSION OF UTERUS-UNSP	57
*66522	INVERS UTERUS-DEL W P/P	
66524	INVERS UTERUS-POSTPART	57
66530	LACERAT OF CERVIX-UNSPEC	57
*66531	LACERAT OF CERVIX-DELIV	
66534	LACER OF CERVIX-POSTPART	57
66540	HIGH VAGINAL LACER-UNSP	57
*66541	HIGH VAGINAL LACER-DELIV	
66544	HIGH VAGINAL LAC-POSTPAR	57
66550	OB INJ PELV ORG NEC-UNSP	57
*66551	OB INJ PELV ORG NEC-DEL	
66554	INJ PELV ORG NEC-POSTPAR	57
66560	DAMAGE TO PELVIC JT-UNSP	57
*66561	DAMAGE TO PELVIC JT-DEL	
66564	DAMAGE PELVIC JT-POSTPAR	57
66570	OB PELVIC HEMATOMA-UNSP	57
*66571	OB PELVIC HEMATOMA-DELIV	
*66572	PELVIC HEMATOM-DEL W PP	
66574	PELVIC HEMATOMA-POSTPART	57
66580	OB TRAUMA NEC-UNSPEC	57
*66581	OB TRAUMA NEC-DELIVERED	
*66582	OB TRAUMA NEC-DEL W P/P	
66583	OB TRAUMA NEC-ANTEPARTUM	57
66584	OB TRAUMA NEC-POSTPARTUM	57
66590	OB TRAUMA NOS-UNSPEC	57
*66591	OB TRAUMA NOS-DELIVERED	
*66592	OB TRAUMA NOS-DEL W P/P	
66593	OB TRAUMA NOS-ANTEPARTUM	57
66594	OB TRAUMA NOS-POSTPARTUM	57
66600	THIRD-STAGE HEM-UNSPEC	57
*66602	THRD-STAGE HEM-DEL W P/P	
66604	THIRD-STAGE HEM-POSTPART	57
66610	POSTPARTUM HEM NEC-UNSP	57
*66612	POSTPA HEM NEC-DEL W P/P	
66614	POSTPART HEM NEC-POSTPAR	57
66620	DELAY P/PART HEM-UNSPEC	57
*66622	DELAY P/P HEM-DEL W P/P	
66624	DELAY P/PART HEM-POSTPAR	57
66630	POSTPART COAGUL DEF-UNSP	57
*66632	P/P COAG DEF-DEL W P/P	
66634	POSTPART COAG DEF-POSTPA	57
66700	RETAIN PLACENTA NOS-UNSP	57
*66702	RETND PLAC NOS-DEL W P/P	

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
66704	RETAIN PLAC NOS-POSTPART	57
66710	RETAIN PROD CONCEPT-UNSP	57
*66712	RET PROD CONC-DEL W P/P	
66714	RET PROD CONCEPT-POSTPAR	57
66800	PULM COMPL IN DEL-UNSPEC	57
*66801	PULM COMPL IN DEL-DELIV	
*66802	PULM COMPLIC-DEL W P/P	
66803	PULM COMPLICAT-ANTEPART	57
66804	PULM COMPLICAT-POSTPART	57
66810	HEART COMPL IN DEL-UNSP	57
*66811	HEART COMPL IN DEL-DELIV	
*66812	HEART COMPL-DEL W P/P	
66813	HEART COMPLIC-ANTEPART	57
66814	HEART COMPLIC-POSTPART	57
66820	CNS COMPL LABOR/DEL-UNSP	57
*66821	CNS COMPL LAB/DEL-DELIV	
*66822	CNS COMPLIC-DEL W P/P	
66823	CNS COMPL IN DEL-ANTEPAR	57
66824	CNS COMPL IN DEL-POSTPAR	57
66880	ANESTH COMP DEL NEC-UNSP	57
*66881	ANESTH COMPL NEC-DELIVER	
*66882	ANESTH COMPL NEC-DEL P/P	
66883	ANESTH COMPL ANTEPARTUM	57
66884	ANESTH COMPL-POSTPARTUM	57
66890	ANESTH COMP DEL NOS-UNSP	57
*66891	ANESTH COMPL NOS-DELIVER	
*66892	ANESTH COMPL NOS-DEL P/P	
66893	ANESTH COMPL-ANTEPARTUM	57
66894	ANESTH COMPL-POSTPARTUM	57
66900	MATERNAL DISTRESS-UNSPEC	57
*66901	MATERNAL DISTRESS-DELIV	
*66902	MATERN DISTRES-DEL W P/P	
66903	MATERN DISTRESS-ANTEPAR	57
66904	MATERN DISTRESS-POSTPART	57
66910	OBSTETRIC SHOCK-UNSPEC	57
*66911	OBSTETRIC SHOCK-DELIVER	
*66912	OBSTET SHOCK-DELIV W P/P	
66913	OBSTETRIC SHOCK-ANTEPAR	57
66914	OBSTETRIC SHOCK-POSTPART	57
66920	MATERN HYPOTENS SYN-UNSP	57
*66921	MATERN HYPOTEN SYN-DELIV	
*66922	MATERN HYPOTEN-DEL W P/P	
66923	MATERN HYPOTENS-ANTEPAR	57
66924	MATERN HYPOTENS-POSTPART	57
66930	AC REN FAIL W DELIV-UNSP	57
*66932	AC REN FAIL-DELIV W P/P	
66934	AC RENAL FAILURE-POSTPAR	57
66940	OTH OB SURG COMPL-UNSPEC	57
*66941	OTH OB COMPL-DELIVERED	
*66942	OTH OB COMPL-DELIV W P/P	
66943	COMPLC OB SURG ANTEPRTM	56
66944	OTH OB SURG COMPL-POSTPA	57
66950	FORCEP DELIV NOS-UNSPEC	57
*66951	FORCEP DELIV NOS-DELIVER	
66960	BREECH EXTR NOS-UNSPEC	57
*66961	BREECH EXTR NOS-DELIVER	
66970	CESAREAN DELIV NOS-UNSP	57
*66971	CESAREAN DELIVERY NOS	
*66980	COMPL LAB/DELIV NEC-UNSP	
*66981	COMP LAB/DELIV NEC-DELIV	
*66982	COMPL DEL NEC-DEL W P/P	
66983	COMPL DELIV NEC-ANTEPAR	57
66984	COMPL DELIV NEC-POSTPART	57
66990	COMPL LAB/DELIV NOS-UNSP	57
*66991	COMP LAB/DELIV NOS-DELIV	
*66992	COMPL DEL NOS-DEL W P/P	
66993	COMPL DELIV NOS-ANTEPAR	57
66994	COMPL DELIV NOS-POSTPART	57
67000	MAJOR PUERP INFECT-UNSP	57
*67002	MAJOR PUERP INF-DEL P/P	
67004	MAJOR PUERP INF-POSTPART	57
67100	VARIC VEIN LEG PREG-UNSP	57
*67101	VARICOSE VEIN LEG-DELIV	
*67102	VARIC VEIN LEG-DEL W P/P	
67103	VARIC VEIN LEG-ANTEPART	57
67104	VARIC VEIN LEG-POSTPART	57

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
67110	VARIC VULVA PREG-UNSPEC	57
*67111	VARICOSE VULVA-DELIVERED	
*67112	VARICOSE VULVA-DEL W P/P	
67113	VARICOSE VULVA-ANTEPART	57
67114	VARICOSE VULVA-POSTPART	57
67120	THROMBOPHLEB PREG-UNSPEC	57
*67121	THROMBOPHLEBITIS-DELIVER	
*67122	THROMBOPHLEB-DELIV W P/P	
67123	THROMBOPHLEBIT-ANTEPART	57
67124	THROMBOPHLEBIT-POSTPART	57
67130	DEEP THROMB ANTEPAR-UNSP	57
*67131	DEEP THROM ANTEPAR-DELIV	
67133	DEEP VEIN THROMB-ANTEPAR	57
67140	DEEP THROMB POSTPAR-UNSP	57
*67142	THROMB POSTPAR-DEL W P/P	
67144	DEEP VEIN THROMB-POSTPAR	57
67150	THROMBOSIS NEC PREG-UNSP	57
*67151	THROMBOSIS NEC-DELIVERED	
*67152	THROMB NEC-DELIV W P/P	
67153	THROMBOSIS NEC-ANTEPART	57
67154	THROMBOSIS NEC-POSTPART	57
67180	VEN COMPL PREG NEC-UNSP	57
*67181	VENOUS COMPL NEC-DELIVER	
*67182	VEN COMP NEC-DELIV W P/P	
67183	VENOUS COMPL NEC-ANTEPAR	57
67184	VENOUS COMPL NEC-POSTPAR	57
67190	VEN COMPL PREG NOS-UNSP	57
*67191	VENOUS COMPL NOS-DELIVER	
*67192	VEN COMP NOS-DELIV W P/P	
67193	VENOUS COMPL NOS-ANTEPAR	57
67194	VENOUS COMPL NOS-POSTPAR	57
67200	PUERPERAL PYREXIA-UNSPEC	57
*67202	PUERP PYREXIA-DEL W P/P	
67204	PUERP PYREXIA-POSTPARTUM	57
67300	OB AIR EMBOLISM-UNSPEC	57
*67301	OB AIR EMBOLISM-DELIVER	
*67302	OB AIR EMBOL-DELIV W P/P	
67303	OB AIR EMBOLISM-ANTEPART	57
67304	OB AIR EMBOLISM-POSTPART	57
67310	AMNIOTIC EMBOLISM-UNSPEC	57
*67311	AMNIOTIC EMBOLISM-DELIV	
*67312	AMNIOT EMBOL-DELIV W P/P	
67313	AMNIOTIC EMBOL-ANTEPART	57
67314	AMNIOTIC EMBOL-POSTPART	57
67320	OB PULM EMBOL NOS-UNSPEC	57
*67321	PULM EMBOL NOS-DELIVERED	
*67322	PULM EMBOL NOS-DEL W P/P	
67323	PULM EMBOL NOS-ANTEPART	57
67324	PULM EMBOL NOS-POSTPART	57
67330	OB PYEMIC EMBOL-UNSPEC	57
*67331	OB PYEMIC EMBOL-DELIVER	
*67332	OB PYEM EMBOL-DEL W P/P	
67333	OB PYEMIC EMBOL-ANTEPART	57
67334	OB PYEMIC EMBOL-POSTPART	57
67380	OB PULMON EMBOL NEC-UNSP	57
*67381	PULMON EMBOL NEC-DELIVER	
*67382	PULM EMBOL NEC-DEL W P/P	
67383	PULMON EMBOL NEC-ANTEPAR	57
67384	PULMON EMBOL NEC-POSTPAR	57
67400	PUERP CEREBVASC DIS-UNSP	57
*67401	PUERP CEREBVAS DIS-DELIV	
*67402	CEREBVAS DIS-DELIV W P/P	
67403	CEREBROVASC DIS-ANTEPART	57
67404	CEREBROVASC DIS-POSTPART	57
67410	DISRUPT C-SECT WND-UNSP	57
*67412	DISRUPT C-SECT-DEL W P/P	
67414	DISRUPT C-SECT-POSTPART	57
67420	DISRUPT PERINEUM-UNSPEC	57
*67422	DISRUPT PERIN-DEL W P/P	
67424	DISRUPT PERINEUM-POSTPAR	57
67430	OB SURG COMPL NEC-UNSPEC	57
*67432	OB SURG COMPL-DEL W P/P	
67434	OB SURG COMP NEC-POSTPAR	57
67440	PLACENTAL POLYP-UNSPEC	57
67442	PLACENT POLYP-DEL W P/P	
67444	PLACENTAL POLYP-POSTPART	57

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
67480	PUERP COMPL NEC-UNSPEC	57
*67482	PUERP COMP NEC-DEL W P/P	
67484	PUERP COMPL NEC-POSTPART	57
67490	PUERP COMPL NOS-UNSPEC	57
*67492	PUERP COMP NOS-DEL W P/P	
67494	PUERP COMPL NOS-POSTPART	57
67500	INFECT NIPPLE PREG-UNSP	57
67501	INFECT NIPPLE-DELIVERED	57
67502	INFECT NIPPLE-DEL W P/P	57
67503	INFECT NIPPLE-ANTEPARTUM	57
67504	INFECT NIPPLE-POSTPARTUM	57
67510	BREAST ABSCESS PREG-UNSP	57
67511	BREAST ABSCESS-DELIVERED	57
67512	BREAST ABSCESS-DEL W P/P	57
67513	BREAST ABSCESS-ANTEPART	57
67514	BREAST ABSCESS-POSTPART	57
67520	MASTITIS IN PREG-UNSPEC	57
67521	MASTITIS-DELIVERED	57
67522	MASTITIS-DELIV W P/P	57
67523	MASTITIS-ANTEPARTUM	57
67524	MASTITIS-POSTPARTUM	57
67580	BREAST INF PREG NEC-UNSP	57
67581	BREAST INFECT NEC-DELIV	57
67582	BREAST INF NEC-DEL W P/P	57
67583	BREAST INF NEC-ANTEPART	57
67584	BREAST INF NEC-POSTPART	57
67590	BREAST INF PREG NOS-UNSP	57
67591	BREAST INFECT NOS-DELIV	57
67592	BREAST INF NOS-DEL W P/P	57
67593	BREAST INF NOS-ANTEPART	57
67594	BREAST INF NOS-POSTPART	57
67600	RETRACT NIPPLE PREG-UNSP	57
67601	RETRACTED NIPPLE-DELIVER	57
67602	RETRACT NIPPLE-DEL W P/P	57
67603	RETRACT NIPPLE-ANTEPART	57
67604	RETRACT NIPPLE-POSTPART	57
67610	CRACKED NIPPLE PREG-UNSP	57
67611	CRACKED NIPPLE-DELIVERED	57
67612	CRACKED NIPPLE-DEL W P/P	57
67613	CRACKED NIPPLE-ANTEPART	57
67614	CRACKED NIPPLE-POSTPART	57
67620	BREAST ENGORGE-UNSPEC	57
67621	BREAST ENGORGE-DELIVERED	57
67622	BREAST ENGORGE-DEL W P/P	57
67623	BREAST ENGORGE-ANTEPART	57
67624	BREAST ENGORGE-POSTPART	57
67630	BREAST DIS PREG NEC-UNSP	57
67631	BREAST DIS NEC-DELIVERED	57
67632	BREAST DIS NEC-DEL W P/P	57
67633	BREAST DIS NEC-ANTEPART	57
67634	BREAST DIS NEC-POSTPART	57
67640	LACTATION FAIL-UNSPEC	57
67641	LACTATION FAIL-DELIVERED	57
67642	LACTATION FAIL-DEL W P/P	57
67643	LACTATION FAIL-ANTEPART	57
67644	LACTATION FAIL-POSTPART	57
67650	SUPPR LACTATION-UNSPEC	57
67651	SUPPR LACTATION-DELIVER	57
67652	SUPPR LACTAT-DEL W P/P	57
67653	SUPPR LACTATION-ANTEPAR	57
67654	SUPPR LACTATION-POSTPART	57
67660	GALACTORRHEA PREG-UNSPEC	57
67661	GALACTORRHEA-DELIVERED	57
67662	GALACTORRHEA-DEL W P/P	57
67663	GALACTORRHEA-ANTEPARTUM	57
67664	GALACTORRHEA-POSTPARTUM	57
67680	LACTATION DIS NEC-UNSPEC	57
67681	LACTATION DIS NEC-DELIV	57
67682	LACTAT DIS NEC-DEL W P/P	57
67683	LACTAT DIS NEC-ANTEPART	57
67684	LACTAT DIS NEC-POSTPART	57
67690	LACTATION DIS NOS-UNSPEC	57
67691	LACTATION DIS NOS-DELIV	57
67692	LACTAT DIS NOS-DEL W P/P	57
67693	LACTAT DIS NOS-ANTEPART	57
67694	LACTAT DIS NOS-POSTPART	57

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
677	LATE EFFCT CMPLCATN PREG	11
6800	CARBUNCLE OF FACE	18
6801	CARBUNCLE OF NECK	18
6802	CARBUNCLE OF TRUNK	18
6803	CARBUNCLE OF ARM	18
6804	CARBUNCLE OF HAND	18
6805	CARBUNCLE OF BUTTOCK	18
6806	CARBUNCLE OF LEG	18
6807	CARBUNCLE OF FOOT	18
6808	CARBUNCLE, SITE NEC	18
6809	CARBUNCLE NOS	18
68100	CELLULITIS, FINGER NOS	18
68101	FELON	18
68102	ONYCHIA OF FINGER	18
68110	CELLULITIS, TOE NOS	18
68111	ONYCHIA OF TOE	18
6819	CELLULITIS OF DIGIT NOS	18
6820	CELLULITIS OF FACE	18
6821	CELLULITIS OF NECK	18
6822	CELLULITIS OF TRUNK	18
6823	CELLULITIS OF ARM	18
6824	CELLULITIS OF HAND	18
6825	CELLULITIS OF BUTTOCK	18
6826	CELLULITIS OF LEG	18
6827	CELLULITIS OF FOOT	18
6828	CELLULITIS, SITE NEC	18
6829	CELLULITIS NOS	18
683	ACUTE LYMPHADENITIS	86
684	IMPETIGO	18
6850	PILONIDAL CYST W ABSCESS	18
6851	PILONIDAL CYST W/O ABSC	18
6861	PYOGENIC GRANULOMA	18
6868	LOCAL SKIN INFECTION NEC	18
6869	LOCAL SKIN INFECTION NOS	18
69010	SEBRRHEIC DERMATITIS NOS	18
69011	SEBORRHEA CAPITIS	18
69012	SBRHEIC INFANTL DRMTITIS	18
69018	SEBRRHEIC DERMATITIS NEC	18
6908	ERYTHMTSQUAMOUS DERM NEC	18
6910	DIAPER OR NAPKIN RASH	18
6918	OTHER ATOPIC DERMATITIS	18
6920	DETERGENT DERMATITIS	18
6921	OIL & GREASE DERMATITIS	18
6922	SOLVENT DERMATITIS	18
6923	TOPICAL MED DERMATITIS	18
6924	CHEMICAL DERMATITIS NEC	18
6925	TOPICAL FOOD DERMATITIS	18
6926	DERMATITIS DUE TO PLANT	18
69270	SOLAR DERMATITIS NOS	18
69271	SUNBURN	18
69272	ACT DRMTITIS SOLAR RDIAT	18
69273	ACTNC RETIC ACTNC GRNLMA	18
69274	OTH CHR DRMTIT SOLAR RAD	18
69279	OTH DERMATITIS SOLAR RAD	18
69281	COSMETIC DERMATITIS	18
69282	DERMATITIS OTH RADIATION	18
69283	DERMATITIS METALS	18
69289	DERMATITIS NEC	18
6929	DERMATITIS NOS	18
6930	DRUG DERMATITIS NOS	18
6931	DERMAT D/T FOOD INGEST	18
6938	DERMAT D/T INT AGENT NEC	18
6939	DERMAT D/T INT AGENT NOS	18
6940	DERMATITIS HERPETIFORMIS	18
6941	SUBCORNEAL PUST DERMATOS	68
6942	JUVEN DERMAT HERPETIFORM	18
6943	IMPETIGO HERPETIFORMIS	18
6944	PEMPHIGUS	18
6945	PEMPHIGOID	18
69460	BN MUCOUS MEMB PEMPH NOS	18
69461	OCULAR PEMPHIGUS	68
6948	BULLOUS DERMATOSES NEC	18
6949	BULLOUS DERMATOSES NOS	18
6950	TOXIC ERYTHEMA	18
6951	ERYTHEMA MULTIFORME	18
6952	ERYTHEMA NODOSUM	18

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
6953	ROSACEA	18
6954	LUPUS ERYTHEMATOSUS	18
69581	RITTER'S DISEASE	18
69589	ERYTHEMATOUS COND NEC	18
6959	ERYTHEMATOUS COND NOS	18
6960	PSORIATIC ARTHROPATHY	24
6961	OTHER PSORIASIS	18
6962	PARAPSORIASIS	18
6963	PITYRIASIS ROSEA	18
6964	PITYRIASIS RUBRA PILARIS	18
6965	PITYRIASIS NEC & NOS	18
6968	PSORIAS RELATED DIS NEC	18
6970	LICHEN PLANUS	18
6971	LICHEN NITIDUS	18
6978	LICHEN NEC	18
6979	LICHEN NOS	18
6980	PRURITUS ANI	18
6981	PRURITUS OF GENITALIA	53
6982	PRURIGO	18
6983	LICHENIFICATION	18
6984	DERMATITIS FACTITIA	18
6988	PRURITIC CONDITIONS NEC	18
6989	PRURITIC DISORDER NOS	18
700	CORNS AND CALLOSITIES	18
7010	CIRCUMSCRIBE SCLERODERMA	18
7011	KERATODERMA, ACQUIRED	18
7012	ACQ ACANTHOSIS NIGRICANS	18
7013	STRIAE ATROPHICAE	18
7014	KELOID SCAR	18
7015	ABNORMAL GRANULATION NEC	18
7018	SKIN HYPERTRO/ATROPH NEC	18
7019	SKIN HYPERTRO/ATROPH NOS	18
7020	ACTINIC KERATOSIS	18
70211	INFLAMED SBRHEIC KERATOS	18
70219	OTHER SBORHEIC KERATOSIS	18
7028	OTHER SPECF DERMATOSES	18
7030	INGROWING NAIL	18
7038	DISEASES OF NAIL NEC	18
7039	DISEASE OF NAIL NOS	18
70400	ALOPECIA NOS	18
70401	ALOPECIA AREATA	18
70402	TELOGEN EFFLUVIUM	18
70409	ALOPECIA NEC	18
7041	HIRSUTISM	18
7042	ABNORMALITIES OF HAIR	18
7043	VARIATIONS IN HAIR COLOR	18
7048	HAIR DISEASES NEC	18
7049	HAIR DISEASE NOS	18
7050	ANHIDROSIS	18
7051	PRICKLY HEAT	18
70581	DYSHIDROSIS	18
70582	FOX-FORDYCE DISEASE	18
70583	HIDRADENITIS	18
70589	SWEAT GLAND DISORDER NEC	18
7059	SWEAT GLAND DISORDER NOS	18
7060	ACNE VARIOLIFORMIS	18
7061	ACNE NEC	18
7062	SEBACEOUS CYST	18
7063	SEBORRHEA	18
7068	SEBACEOUS GLAND DIS NEC	18
7069	SEBACEOUS GLAND DIS NOS	18
7070	DECUBITUS ULCER	18
7071	CHRONIC ULCER OF LEG	18
7078	CHRONIC SKIN ULCER NEC	18
7079	CHRONIC SKIN ULCER NOS	18
7080	ALLERGIC URTICARIA	18
7081	IDIOPATHIC URTICARIA	18
7082	URTICARIA FROM COLD/HEAT	18
7083	DERMATOGRAPHIC URTICARIA	18
7084	VIBRATORY URTICARIA	18
7085	CHOLINERGIC URTICARIA	18
7088	URTICARIA NEC	18
7089	URTICARIA NOS	18
70900	DYSCHROMIA, UNSPECIFIED	18
70901	VITILIGO	18
70909	OTHER DYSCHROMIA	18

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
7091	VASCULAR DISORD OF SKIN	18
7092	SCAR & FIBROSIS OF SKIN	18
7093	DEGENERATIVE SKIN DISORD	18
7094	FOREIGN BODY GRANUL-SKIN	18
7098	SKIN DISORDERS NEC	18
7099	SKIN DISORDER NOS	18
7100	SYST LUPUS ERYTHEMATOSUS	86
7101	SYSTEMIC SCLEROSIS	86
7102	SICCA SYNDROME	86
7103	DERMATOMYOSITIS	86
7104	POLYMYOSITIS	86
7105	EOSINOPHILIA MYALGIA SND	24
7108	DIFF CONNECT TIS DIS NEC	24
7109	DIFF CONNECT TIS DIS NOS	24
71100	PYOGEN ARTHRITIS-UNSPEC	24
71101	PYOGEN ARTHRITIS-SHLDER	24
71102	PYOGEN ARTHRITIS-UP/ARM	24
71103	PYOGEN ARTHRITIS-FOREARM	24
71104	PYOGEN ARTHRITIS-HAND	24
71105	PYOGEN ARTHRITIS-PELVIS	24
71106	PYOGEN ARTHRITIS-L/LEG	24
71107	PYOGEN ARTHRITIS-ANKLE	24
71108	PYOGEN ARTHRITIS NEC	24
71109	PYOGEN ARTHRITIS-MULT	24
71110	REITER ARTHRITIS-UNSPEC	24
71111	REITER ARTHRITIS-SHLDER	24
71112	REITER ARTHRITIS-UP/ARM	24
71113	REITER ARTHRITIS-FOREARM	24
71114	REITER ARTHRITIS-HAND	24
71115	REITER ARTHRITIS-PELVIS	24
71116	REITER ARTHRITIS-L/LEG	24
71117	REITER ARTHRITIS-ANKLE	24
71118	REITER ARTHRITIS NEC	24
71119	REITER ARTHRITIS-MULT	24
71120	BEHCET ARTHRITIS-UNSPEC	24
71121	BEHCET ARTHRITIS-SHLDER	24
71122	BEHCET ARTHRITIS-UP/ARM	24
71123	BEHCET ARTHRITIS-FOREARM	24
71124	BEHCET ARTHRITIS-HAND	24
71125	BEHCET ARTHRITIS-PELVIS	24
71126	BEHCET ARTHRITIS-L/LEG	24
71127	BEHCET ARTHRITIS-ANKLE	24
71128	BEHCET ARTHRITIS NEC	24
71129	BEHCET ARTHRITIS-MULT	24
71130	DYSENTER ARTHRIT-UNSPEC	24
71131	DYSENTER ARTHRIT-SHLDER	24
71132	DYSENTER ARTHRIT-UP/ARM	24
71133	DYSENTER ARTHRIT-FOREARM	24
71134	DYSENTER ARTHRIT-HAND	24
71135	DYSENTER ARTHRIT-PELVIS	24
71136	DYSENTER ARTHRIT-L/LEG	24
71137	DYSENTER ARTHRIT-ANKLE	24
71138	DYSENTER ARTHRIT NEC	24
71139	DYSENTER ARTHRIT-MULT	24
71140	BACT ARTHRITIS-UNSPEC	24
71141	BACT ARTHRITIS-SHLDER	24
71142	BACT ARTHRITIS-UP/ARM	24
71143	BACT ARTHRITIS-FOREARM	24
71144	BACT ARTHRITIS-HAND	24
71145	BACT ARTHRITIS-PELVIS	24
71146	BACT ARTHRITIS-L/LEG	24
71147	BACT ARTHRITIS-ANKLE	24
71148	BACT ARTHRITIS NEC	24
71149	BACT ARTHRITIS-MULT	24
71150	VIRAL ARTHRITIS-UNSPEC	24
71151	VIRAL ARTHRITIS-SHLDER	24
71152	VIRAL ARTHRITIS-UP/ARM	24
71153	VIRAL ARTHRITIS-FOREARM	24
71154	VIRAL ARTHRITIS-HAND	24
71155	VIRAL ARTHRITIS-PELVIS	24
71156	VIRAL ARTHRITIS-L/LEG	24
71157	VIRAL ARTHRITIS-ANKLE	24
71158	VIRAL ARTHRITIS NEC	24
71159	VIRAL ARTHRITIS-MULT	24
71160	MYCOTIC ARTHRITIS-UNSPEC	24
71161	MYCOTIC ARTHRITIS-SHLDER	24

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
71162	MYCOTIC ARTHRITIS-UP/ARM	24
71163	MYCOTIC ARTHRIT-FOREARM	24
71164	MYCOTIC ARTHRITIS-HAND	24
71165	MYCOTIC ARTHRITIS-PELVIS	24
71166	MYCOTIC ARTHRITIS-L/LEG	24
71167	MYCOTIC ARTHRITIS-ANKLE	24
71168	MYCOTIC ARTHRITIS NEC	24
71169	MYCOTIC ARTHRITIS-MULT	24
71170	HELMINTH ARTHRIT-UNSPEC	24
71171	HELMINTH ARTHRIT-SHLDER	24
71172	HELMINTH ARTHRIT-UP/ARM	24
71173	HELMINTH ARTHRIT-FOREARM	24
71174	HELMINTH ARTHRIT-HAND	24
71175	HELMINTH ARTHRIT-PELVIS	24
71176	HELMINTH ARTHRIT-L/LEG	24
71177	HELMINTH ARTHRIT-ANKLE	24
71178	HELMINTH ARTHRIT NEC	24
71179	HELMINTH ARTHRIT-MULT	24
71180	INF ARTHRITIS NEC-UNSPEC	24
71181	INF ARTHRITIS NEC-SHLDER	24
71182	INF ARTHRITIS NEC-UP/ARM	24
71183	INF ARTHRIT NEC-FOREARM	24
71184	INF ARTHRITIS NEC-HAND	24
71185	INF ARTHRITIS NEC-PELVIS	24
71186	INF ARTHRITIS NEC-L/LEG	24
71187	INF ARTHRITIS NEC-ANKLE	24
71188	INF ARTHRIT NEC-OTH SITE	24
71189	INF ARTHRITIS NEC-MULT	24
71190	INF ARTHRITIS NOS-UNSPEC	24
71191	INF ARTHRITIS NOS-SHLDER	24
71192	INF ARTHRITIS NOS-UP/ARM	24
71193	INF ARTHRIT NOS-FOREARM	24
71194	INF ARTHRIT NOS-HAND	24
71195	INF ARTHRIT NOS-PELVIS	24
71196	INF ARTHRIT NOS-L/LEG	24
71197	INF ARTHRIT NOS-ANKLE	24
71198	INF ARTHRIT NOS-OTH SITE	24
71199	INF ARTHRITIS NOS-MULT	24
71210	DICALC PHOS CRYST-UNSPEC	24
71211	DICALC PHOS CRYST-SHLDER	24
71212	DICALC PHOS CRYST-UP/ARM	24
71213	DICALC PHOS CRYS-FOREARM	24
71214	DICALC PHOS CRYST-HAND	24
71215	DICALC PHOS CRYST-PELVIS	24
71216	DICALC PHOS CRYST-L/LEG	24
71217	DICALC PHOS CRYST-ANKLE	24
71218	DICALC PHOS CRY-SITE NEC	24
71219	DICALC PHOS CRYST-MULT	24
71220	PYROPHOSPH CRYST-UNSPEC	24
71221	PYROPHOSPH CRYST-SHLDER	24
71222	PYROPHOSPH CRYST-UP/ARM	24
71223	PYROPHOSPH CRYST-FOREARM	24
71224	PYROPHOSPH CRYST-HAND	24
71225	PYROPHOSPH CRYST-PELVIS	24
71226	PYROPHOSPH CRYST-L/LEG	24
71227	PYROPHOSPH CRYST-ANKLE	24
71228	PYROPHOS CRYST-SITE NEC	24
71229	PYROPHOS CRYST-MULT	24
71230	CHONDROCALCIN NOS-UNSPEC	24
71231	CHONDROCALCIN NOS-SHLDER	24
71232	CHONDROCALCIN NOS-UP/ARM	24
71233	CHONDROCALC NOS-FOREARM	24
71234	CHONDROCALCIN NOS-HAND	24
71235	CHONDROCALCIN NOS-PELVIS	24
71236	CHONDROCALCIN NOS-L/LEG	24
71237	CHONDROCALCIN NOS-ANKLE	24
71238	CHONDROCALC NOS-OTH SITE	24
71239	CHONDROCALCIN NOS-MULT	24
71280	CRYST ARTHROP NEC-UNSPEC	24
71281	CRYST ARTHROP NEC-SHLDER	24
71282	CRYST ARTHROP NEC-UP/ARM	24
71283	CRYS ARTHROP NEC-FOREARM	24
71284	CRYST ARTHROP NEC-HAND	24
71285	CRYST ARTHROP NEC-PELVIS	24
71286	CRYST ARTHROP NEC-L/LEG	24
71287	CRYST ARTHROP NEC-ANKLE	24

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
71288	CRY ARTHROP NEC-OTH SITE	24
71289	CRYST ARTHROP NEC-MULT	24
71290	CRYST ARTHROP NOS-UNSPEC	24
71291	CRYST ARTHROP NOS-SHLDR	24
71292	CRYST ARTHROP NOS-UP/ARM	24
71293	CRYS ARTHROP NOS-FOREARM	24
71294	CRYST ARTHROP NOS-HAND	24
71295	CRYST ARTHROP NOS-PELVIS	24
71296	CRYST ARTHROP NOS-L/LEG	24
71297	CRYST ARTHROP NOS-ANKLE	24
71298	CRY ARTHROP NOS-OTH SITE	24
71299	CRYST ARTHROP NOS-MULT	24
7130	ARTHROP W ENDOCR/MET DIS	24
7131	ARTHROP W NONINF GI DIS	24
7132	ARTHROPATH W HEMATOL DIS	24
7133	ARTHROPATHY W SKIN DIS	24
7134	ARTHROPATHY W RESP DIS	24
7135	ARTHROPATHY W NERVE DIS	24
7136	ARTHROP W HYPERSEN REACT	24
7137	ARTHROP W SYSTEM DIS NEC	24
7138	ARTHROP W OTH DIS NEC	24
7140	RHEUMATOID ARTHRITIS	24
7141	FELTY'S SYNDROME	24
7142	SYST RHEUM ARTHRITIS NEC	24
71430	JUV RHEUM ARTHRITIS NOS	24
71431	POLYART JUV RHEUM ARTHR	24
71432	PAUCIART JUV RHEUM ARTHR	24
71433	MONOART JUV RHEUM ARTHR	24
7144	CHR POSTRHEUM ARTHRITIS	24
71481	RHEUMATOID LUNG	33
71489	INFLAMM POLYARTHROP NEC	24
7149	INFLAMM POLYARTHROP NOS	24
71500	GENERAL OSTEOARTHROSIS	24
71504	GEN OSTEOARTHROS-HAND	24
71509	GENERAL OSTEOARTHROSIS	24
71510	LOC PRIM OSTEOART-UNSPEC	24
71511	LOC PRIM OSTEOART-SHLDER	24
71512	LOC PRIM OSTEOART-UP/ARM	24
71513	LOC PRIM OSTEOART-FORARM	24
71514	LOC PRIM OSTEOARTH-HAND	24
71515	LOC PRIM OSTEOART-PELVIS	24
71516	LOC PRIM OSTEOART-L/LEG	24
71517	LOC PRIM OSTEOARTH-ANKLE	24
71518	LOC PRIM OSTEOARTHR NEC	24
71520	LOC 2ND OSTEOARTH-UNSPEC	24
71521	LOC 2ND OSTEOARTH-SHLDER	24
71522	LOC 2ND OSTEOARTH-UP/ARM	24
71523	LOC 2ND OSTEOART-FOREARM	24
71524	LOC 2ND OSTEOARTHRO-HAND	24
71525	LOC 2ND OSTEOARTH-PELVIS	24
71526	LOC 2ND OSTEOARTHR-L/LEG	24
71527	LOC 2ND OSTEOARTHR-ANKLE	24
71528	LOC 2ND OSTEOARTHROS NEC	24
71530	LOC OSTEOARTH NOS-UNSPEC	24
71531	LOC OSTEOARTH NOS-SHLDER	24
71532	LOC OSTEOARTH NOS-UP/ARM	24
71533	LOC OSTEOART NOS-FOREARM	24
71534	LOC OSTEOARTH NOS-HAND	24
71535	LOC OSTEOARTH NOS-PELVIS	24
71536	LOC OSTEOARTH NOS-L/LEG	24
71537	LOC OSTEOARTH NOS-ANKLE	24
71538	LOC OSTEOAR NOS-SITE NEC	24
71580	OSTEOARTHROSIS-MULT SITE	24
71589	OSTEOARTHROSIS-MULT SITE	24
71590	OSTEOARTHROS NOS-UNSPEC	24
71591	OSTEOARTHROS NOS-SHLDER	24
71592	OSTEOARTHROS NOS-UP/ARM	24
71593	OSTEOARTHROS NOS-FOREARM	24
71594	OSTEOARTHROS NOS-HAND	24
71595	OSTEOARTHROS NOS-PELVIS	24
71596	OSTEOARTHROS NOS-L/LEG	24
71597	OSTEOARTHROS NOS-ANKLE	24
71598	OSTEOARTHRO NOS-OTH SITE	24
71600	KASCHIN-BECK DIS-UNSPEC	24
71601	KASCHIN-BECK DIS-SHLDER	24
71602	KASCHIN-BECK DIS-UP/ARM	24

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
71603	KASCHIN-BECK DIS-FOREARM	24
71604	KASCHIN-BECK DIS-HAND	24
71605	KASCHIN-BECK DIS-PELVIS	24
71606	KASCHIN-BECK DIS-L/LEG	24
71607	KASCHIN-BECK DIS-ANKLE	24
71608	KASCHIN-BECK DIS NEC	24
71609	KASCHIN-BECK DIS-MULT	24
71610	TRAUM ARTHROPATHY-UNSPEC	24
71611	TRAUM ARTHROPATHY-SHLDER	24
71612	TRAUM ARTHROPATHY-UP/ARM	24
71613	TRAUM ARTHROPATH-FOREARM	24
71614	TRAUM ARTHROPATHY-HAND	24
71615	TRAUM ARTHROPATHY-PELVIS	24
71616	TRAUM ARTHROPATHY-L/LEG	24
71617	TRAUM ARTHROPATHY-ANKLE	24
71618	TRAUM ARTHROPATHY NEC	24
71619	TRAUM ARTHROPATHY-MULT	24
71620	ALLERG ARTHRITIS-UNSPEC	24
71621	ALLERG ARTHRITIS-SHLDER	24
71622	ALLERG ARTHRITIS-UP/ARM	24
71623	ALLERG ARTHRITIS-FOREARM	24
71624	ALLERG ARTHRITIS-HAND	24
71625	ALLERG ARTHRITIS-PELVIS	24
71626	ALLERG ARTHRITIS-L/LEG	24
71627	ALLERG ARTHRITIS-ANKLE	24
71628	ALLERG ARTHRITIS NEC	24
71629	ALLERG ARTHRITIS-MULT	24
71630	CLIMACT ARTHRITIS-UNSPEC	24
71631	CLIMACT ARTHRITIS-SHLDER	24
71632	CLIMACT ARTHRITIS-UP/ARM	24
71633	CLIMACT ARTHRIT-FOREARM	24
71634	CLIMACT ARTHRITIS-HAND	24
71635	CLIMACT ARTHRITIS-PELVIS	24
71636	CLIMACT ARTHRITIS-L/LEG	24
71637	CLIMACT ARTHRITIS-ANKLE	24
71638	CLIMACT ARTHRITIS NEC	24
71639	CLIMACT ARTHRITIS-MULT	24
71640	TRANS ARTHROPATHY-UNSPEC	24
71641	TRANS ARTHROPATHY-SHLDER	24
71642	TRANS ARTHROPATHY-UP/ARM	24
71643	TRANS ARTHROPATH-FOREARM	24
71644	TRANS ARTHROPATHY-HAND	24
71645	TRANS ARTHROPATHY-PELVIS	24
71646	TRANS ARTHROPATHY-L/LEG	24
71647	TRANS ARTHROPATHY-ANKLE	24
71648	TRANS ARTHROPATHY NEC	24
71649	TRANS ARTHROPATHY-MULT	24
71650	POLYARTHRITIS NOS-UNSPEC	24
71651	POLYARTHRITIS NOS-SHLDER	24
71652	POLYARTHRITIS NOS-UP/ARM	24
71653	POLYARTHRIT NOS-FOREARM	24
71654	POLYARTHRITIS NOS-HAND	24
71655	POLYARTHRITIS NOS-PELVIS	24
71656	POLYARTHRITIS NOS-L/LEG	24
71657	POLYARTHRITIS NOS-ANKLE	24
71658	POLYARTHRIT NOS-OTH SITE	24
71659	POLYARTHRITIS NOS-MULT	24
71660	MONOARTHRITIS NOS-UNSPEC	24
71661	MONOARTHRITIS NOS-SHLDER	24
71662	MONOARTHRITIS NOS-UP/ARM	24
71663	MONOARTHRIT NOS-FOREARM	24
71664	MONOARTHRITIS NOS-HAND	24
71665	MONOARTHRITIS NOS-PELVIS	24
71666	MONOARTHRITIS NOS-L/LEG	24
71667	MONOARTHRITIS NOS-ANKLE	24
71668	MONOARTHRIT NOS-OTH SITE	24
71680	ARTHROPATHY NEC-UNSPEC	24
71681	ARTHROPATHY NEC-SHLDER	24
71682	ARTHROPATHY NEC-UP/ARM	24
71683	ARTHROPATHY NEC-FOREARM	24
71684	ARTHROPATHY NEC-HAND	24
71685	ARTHROPATHY NEC-PELVIS	24
71686	ARTHROPATHY NEC-L/LEG	24
71687	ARTHROPATHY NEC-ANKLE	24
71688	ARTHROPATHY NEC-OTH SITE	24
71689	ARTHROPATHY NEC-MULT	24

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
71690	ARTHROPATHY NOS-UNSPEC	24
71691	ARTHROPATHY NOS-SHLDER	24
71692	ARTHROPATHY NOS-UP/ARM	24
71693	ARTHROPATHY NOS-FOREARM	24
71694	ARTHROPATHY NOS-HAND	24
71695	ARTHROPATHY NOS-PELVIS	24
71696	ARTHROPATHY NOS-L/LEG	24
71697	ARTHROPATHY NOS-ANKLE	24
71698	ARTHROPATHY NOS-OTH SITE	24
71699	ARTHROPATHY NOS-MULT	24
7170	OLD BUCKET TEAR MED MEN	24
7171	DERANG ANT MED MENISCUS	24
7172	DERANG POST MED MENISCUS	24
7173	DERANG MED MENISCUS NEC	24
71740	DERANG LAT MENISCUS NOS	24
71741	OLD BUCKET TEAR LAT MEN	24
71742	DERANGE ANT LAT MENISCUS	24
71743	DERANG POST LAT MENISCUS	24
71749	DERANG LAT MENISCUS NEC	24
7175	DERANGEMENT MENISCUS NEC	24
7176	LOOSE BODY IN KNEE	24
7177	CHONDROMALACIA PATELLAE	24
71781	OLD DISRUPT LAT COLLAT	24
71782	OLD DISRUPT MED COLLAT	24
71783	OLD DISRUPT ANT CRUCIATE	24
71784	OLD DISRUPT POST CRUCIAT	24
71785	OLD DISRUPT KNEE LIG NEC	24
71789	INT DERANGEMENT KNEE NEC	24
7179	INT DERANGEMENT KNEE NOS	24
71800	ARTIC CARTIL DIS-UNSPEC	24
71801	ARTIC CARTIL DIS-SHLDER	24
71802	ARTIC CARTIL DIS-UP/ARM	24
71803	ARTIC CARTIL DIS-FOREARM	24
71804	ARTIC CARTIL DIS-HAND	24
71805	ARTIC CARTIL DIS-PELVIS	24
71807	ARTIC CARTIL DIS-ANKLE	24
71808	ARTIC CARTIL DIS-JT NEC	24
71809	ARTIC CARTIL DIS-MULT JT	24
71810	LOOSE BODY-UNSPEC	24
71811	LOOSE BODY-SHLDER	24
71812	LOOSE BODY-UP/ARM	24
71813	LOOSE BODY-FOREARM	24
71814	LOOSE BODY-HAND	24
71815	LOOSE BODY-PELVIS	24
71817	LOOSE BODY-ANKLE	24
71818	LOOSE BODY-JOINT NEC	24
71819	LOOSE BODY-MULT JOINTS	24
71820	PATHOL DISLOCAT-UNSPEC	24
71821	PATHOL DISLOCAT-SHLDER	24
71822	PATHOL DISLOCAT-UP/ARM	24
71823	PATHOL DISLOCAT-FOREARM	24
71824	PATHOL DISLOCAT-HAND	24
71825	PATHOL DISLOCAT-PELVIS	24
71826	PATHOL DISLOCAT-L/LEG	24
71827	PATHOL DISLOCAT-ANKLE	24
71828	PATHOL DISLOCAT-JT NEC	24
71829	PATHOL DISLOCAT-MULT JTS	24
71830	RECUR DISLOCAT-UNSPEC	24
71831	RECUR DISLOCAT-SHLDER	24
71832	RECUR DISLOCAT-UP/ARM	24
71833	RECUR DISLOCAT-FOREARM	24
71834	RECUR DISLOCAT-HAND	24
71835	RECUR DISLOCAT-PELVIS	24
71836	RECUR DISLOCAT-L/LEG	24
71837	RECUR DISLOCAT-ANKLE	24
71838	RECUR DISLOCAT-JT NEC	24
71839	RECUR DISLOCAT-MULT JTS	24
71840	JT CONTRACTURE-UNSPEC	24
71841	JT CONTRACTURE-SHLDER	24
71842	JT CONTRACTURE-UP/ARM	24
71843	JT CONTRACTURE-FOREARM	24
71844	JT CONTRACTURE-HAND	24
71845	JT CONTRACTURE-PELVIS	24
71846	JT CONTRACTURE-L/LEG	24
71847	JT CONTRACTURE-ANKLE	24
71848	JT CONTRACTURE-JT NEC	24

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
71849	JT CONTRACTURE-MULT JTS	24
71850	ANKYLOSIS-UNSPEC	24
71851	ANKYLOSIS-SHOULDER	24
71852	ANKYLOSIS-UPPER/ARM	24
71853	ANKYLOSIS-FOREARM	24
71854	ANKYLOSIS-HAND	24
71855	ANKYLOSIS-PELVIS	24
71856	ANKYLOSIS-LOWER/LEG	24
71857	ANKYLOSIS-ANKLE	24
71858	ANKYLOSIS-JOINT NEC	24
71859	ANKYLOSIS-MULT JOINTS	24
71860	PROTRUSIO ACETAB-UNSPEC	24
71865	PROTRUSIO ACETABULI NOS	24
71880	JT DERANGMNT NEC-UNSP JT	24
71881	JT DERANGMENT NEC-SHLDER	24
71882	JT DERANGMENT NEC-UP/ARM	24
71883	JT DERANGMNT NEC-FOREARM	24
71884	JT DERANGEMENT NEC-HAND	24
71885	JT DERANGMENT NEC-PELVIS	24
71886	JT DERANGEMENT NEC-L/LEG	24
71887	JT DERANGEMENT NEC-ANKLE	24
71888	JT DERANGMENT NEC-OTH JT	24
71889	JT DERANGEMENT NEC-MULT	24
71890	JT DERANGMNT NOS-UNSP JT	24
71891	JT DERANGMENT NOS-SHLDER	24
71892	JT DERANGMENT NOS-UP/ARM	24
71893	JT DERANGMNT NOS-FOREARM	24
71894	JT DERANGEMENT NOS-HAND	24
71895	JT DERANGMENT NOS-PELVIS	24
71897	JT DERANGEMENT NOS-ANKLE	24
71898	JT DERANGMENT NOS-OTH JT	24
71899	JT DERANGEMENT NOS-MULT	24
71900	JOINT EFFUSION-UNSPEC	24
71901	JOINT EFFUSION-SHLDER	24
71902	JOINT EFFUSION-UP/ARM	24
71903	JOINT EFFUSION-FOREARM	24
71904	JOINT EFFUSION-HAND	24
71905	JOINT EFFUSION-PELVIS	24
71906	JOINT EFFUSION-L/LEG	24
71907	JOINT EFFUSION-ANKLE	24
71908	JOINT EFFUSION-JT NEC	24
71909	JOINT EFFUSION-MULT JTS	24
71910	HEMARTHROSIS-UNSPEC	24
71911	HEMARTHROSIS-SHLDER	24
71912	HEMARTHROSIS-UP/ARM	24
71913	HEMARTHROSIS-FOREARM	24
71914	HEMARTHROSIS-HAND	24
71915	HEMARTHROSIS-PELVIS	24
71916	HEMARTHROSIS-L/LEG	24
71917	HEMARTHROSIS-ANKLE	24
71918	HEMARTHROSIS-JT NEC	24
71919	HEMARTHROSIS-MULT JTS	24
71920	VILLONOD SYNOVIT-UNSPEC	24
71921	VILLONOD SYNOVIT-SHLDER	24
71922	VILLONOD SYNOVIT-UP/ARM	24
71923	VILLONOD SYNOVIT-FOREARM	24
71924	VILLONOD SYNOVIT-HAND	24
71925	VILLONOD SYNOVIT-PELVIS	24
71926	VILLONOD SYNOVIT-L/LEG	24
71927	VILLONOD SYNOVIT-ANKLE	24
71928	VILLONOD SYNOVIT-JT NEC	24
71929	VILLONOD SYNOVIT-MULT JT	24
71930	PALINDROM RHEUM-UNSPEC	24
71931	PALINDROM RHEUM-SHLDER	24
71932	PALINDROM RHEUM-UP/ARM	24
71933	PALINDROM RHEUM-FOREARM	24
71934	PALINDROM RHEUM-HAND	24
71935	PALINDROM RHEUM-PELVIS	24
71936	PALINDROM RHEUM-L/LEG	24
71937	PALINDROM RHEUM-ANKLE	24
71938	PALINDROM RHEUM-JT NEC	24
71939	PALINDROM RHEUM-MULT JTS	24
71940	JOINT PAIN-UNSPEC	24
71941	JOINT PAIN-SHLDER	24
71942	JOINT PAIN-UP/ARM	24
71943	JOINT PAIN-FOREARM	24

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
71944	JOINT PAIN-HAND	24
71945	JOINT PAIN-PELVIS	24
71946	JOINT PAIN-L/LEG	24
71947	JOINT PAIN-ANKLE	24
71948	JOINT PAIN-JT NEC	24
71949	JOINT PAIN-MULT JTS	24
71950	JT STIFFNESS NEC-UNSPEC	24
71951	JT STIFFNESS NEC-SHLDER	24
71952	JT STIFFNESS NEC-UP/ARM	24
71953	JT STIFFNES NEC-FOREARM	24
71954	JT STIFFNESS NEC-HAND	24
71955	JT STIFFNESS NEC-PELVIS	24
71956	JT STIFFNESS NEC-L/LEG	24
71957	JT STIFFNESS NEC-ANKLE	24
71958	JT STIFFNESS NEC-OTH JT	24
71959	JT STIFFNESS NEC-MULT JT	24
71960	JOINT SYMPT NEC-UNSP JT	24
71961	JOINT SYMPTOM NEC-SHLDER	24
71962	JOINT SYMPTOM NEC-UP/ARM	24
71963	JOINT SYMPT NEC-FOREARM	24
71964	JOINT SYMPTOM NEC-HAND	24
71965	JOINT SYMPTOM NEC-PELVIS	24
71966	JOINT SYMPTOM NEC-L/LEG	24
71967	JOINT SYMPTOM NEC-ANKLE	24
71968	JOINT SYMPTOM NEC-OTH JT	24
71969	JOINT SYMPT NEC-MULT JTS	24
71970	DIFFICULT WALK-UNSPEC	24
71975	DIFFICULT WALK-PELVIS	24
71976	DIFFICULT WALK-LO/LEG	24
71977	DIFFICULT WALK-FOOT	24
71978	DIFFICULT WALK NEC	24
71979	DIFFICULT WALK-MULT	24
71980	JOINT DIS NEC-UNSPEC	24
71981	JOINT DIS NEC-SHLDER	24
71982	JOINT DIS NEC-UP/ARM	24
71983	JOINT DIS NEC-FOREARM	24
71984	JOINT DIS NEC-HAND	24
71985	JOINT DIS NEC-PELVIS	24
71986	JOINT DIS NEC-L/LEG	24
71987	JOINT DIS NEC-ANKLE	24
71988	JOINT DIS NEC-OTH JT	24
71989	JOINT DIS NEC-MULT JTS	24
71990	JOINT DIS NOS-UNSPEC JT	24
71991	JOINT DIS NOS-SHLDER	24
71992	JOINT DIS NOS-UP/ARM	24
71993	JOINT DIS NOS-FOREARM	24
71994	JOINT DIS NOS-HAND	24
71995	JOINT DIS NOS-PELVIS	24
71996	JOINT DIS NOS-L/LEG	24
71997	JOINT DIS NOS-ANKLE	24
71998	JOINT DIS NOS-OTH JT	24
71999	JOINT DIS NOS-MULT JTS	24
7200	ANKYLOSING SPONDYLITIS	24
7201	SPINAL ENTHESOPATHY	24
7202	SACROILIITIS NEC	24
72081	SPONDYLOPATHY IN OTH DIS	24
72089	INFLAM SPONDYLOPATHY NEC	24
7209	INFLAM SPONDYLOPATHY NOS	24
7210	CERVICAL SPONDYLOSIS	24
7211	CERV SPONDYL W MYELOPATH	24
7212	THORACIC SPONDYLOSIS	24
7213	LUMBOSACRAL SPONDYLOSIS	24
72141	SPOND COMPR THOR SP CORD	24
72142	SPOND COMPR LUMB SP CORD	24
7215	KISSING SPINE	24
7216	ANKYL VERT HYPEROSTOSIS	24
7217	TRAUMATIC SPONDYLOPATHY	24
7218	SPINAL DISORDERS NEC	24
72190	SPONDYLOS NOS W/O MYELOP	24
72191	SPONDYLOSIS NOS W MYELOP	24
7220	CERVICAL DISC DISPLACMNT	24
72210	LUMBAR DISC DISPLACEMENT	24
72211	THORACIC DISC DISPLACMNT	24
7222	DISC DISPLACEMENT NOS	24
72230	SCHMORL'S NODES NOS	24
72231	SCHMORLS NODE-THORACIC	24

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
72232	SCHMORLS NODE-LUMBAR	24
72239	SCHMORLS NODE-REGION NEC	24
7224	CERVICAL DISC DEGEN	24
72251	THORACIC DISC DEGEN	24
72252	LUMB/LUMBOSAC DISC DEGEN	24
7226	DISC DEGENERATION NOS	24
72270	DISC DIS W MYELOPATH NOS	24
72271	CERV DISC DIS W MYELOPAT	24
72272	THOR DISC DIS W MYELOPAT	24
72273	LUMB DISC DIS W MYELOPAT	24
72280	POSTLAMINECTOMY SYND NOS	24
72281	POSTLAMINECT SYND-CERV	24
72282	POSTLAMINECT SYND-THORAC	24
72283	POSTLAMINECT SYND-LUMBAR	24
72290	DISC DIS NEC/NOS-UNSPEC	24
72291	DISC DIS NEC/NOS-CERV	24
72292	DISC DIS NEC/NOS-THORAC	24
72293	DISC DIS NEC/NOS-LUMBAR	24
7230	CERVICAL SPINAL STENOSIS	24
7231	CERVICALGIA	24
7232	CERVICOCRANIAL SYNDROME	63
7233	CERVICOBRACHIAL SYNDROME	63
7234	BRACHIAL NEURITIS NOS	63
7235	TORTICOLLIS NOS	24
7236	PANNICULITIS OF NECK	18
7237	OSSIFICATION CERV LIG	24
7238	CERVICAL SYNDROME NEC	24
7239	NECK DISORDER/SYMPT NOS	24
72400	SPINAL STENOSIS NOS	24
72401	SPINAL STENOSIS-THORACIC	24
72402	SPINAL STENOSIS-LUMBAR	24
72409	SPINAL STENOSIS-OTH SITE	24
7241	PAIN IN THORACIC SPINE	24
7242	LUMBAGO	24
7243	SCIATICA	24
7244	LUMBOSACRAL NEURITIS NOS	24
7245	BACKACHE NOS	24
7246	DISORDERS OF SACRUM	24
72470	DISORDER OF COCCYX NOS	24
72471	HYPERMOBILITY OF COCCYX	24
72479	DISORDER OF COCCYX NEC	24
7248	OTHER BACK SYMPTOMS	24
7249	BACK DISORDER NOS	24
725	POLYMYALGIA RHEUMATICA	24
7260	ADHESIVE CAPSULIT SHLDER	24
72610	ROTATOR CUFF SYND NOS	24
72611	CALCIF TENDINITIS SHLDER	24
72612	BICIPITAL TENOSYNOVITIS	24
72619	ROTATOR CUFF DIS NEC	24
7262	SHOULDER REGION DIS NEC	24
72630	ELBOW ENTHESOPATHY NOS	24
72631	MEDIAL EPICONDYLITIS	24
72632	LATERAL EPICONDYLITIS	24
72633	OLECRANON BURSITIS	24
72639	ELBOW ENTHESOPATHY NEC	24
7264	ENTHESOPATHY OF WRIST	24
7265	ENTHESOPATHY OF HIP	24
72660	ENTHESOPATHY OF KNEE NOS	24
72661	PES ANSERINUS TENDINITIS	24
72662	TIBIAL COLL LIG BURSITIS	24
72663	FIBULA COLL LIG BURSITIS	24
72664	PATELLAR TENDINITIS	24
72665	PREPATELLAR BURSITIS	24
72669	ENTHESOPATHY OF KNEE NEC	24
72670	ANKLE ENTHESOPATHY NOS	24
72671	ACHILLES TENDINITIS	24
72672	TIBIALIS TENDINITIS	24
72673	CALCANEAL SPUR	24
72679	ANKLE ENTHESOPATHY NEC	24
7268	PERIPH ENTHESOPATHY NEC	24
72690	ENTHESOPATHY, SITE NOS	24
72691	EXOSTOSIS, SITE NOS	24
72700	SYNOVITIS NOS	24
72701	SYNOVITIS IN OTH DIS	24
72702	GIANT CELL TUMOR TENDON	24
72703	TRIGGER FINGER	24

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
72704	RADIAL STYLOID TENOSYNOV	24
72705	TENOSYNOV HAND/WRIST NEC	24
72706	TENOSYNOVITIS FOOT/ANKLE	24
72709	SYNOVITIS NEC	24
7271	BUNION	24
7272	OCCUPATIONAL BURSITIS	24
7273	BURSITIS NEC	24
72740	SYNOVIAL CYST NOS	24
72741	GANGLION OF JOINT	24
72742	GANGLION OF TENDON	24
72743	GANGLION NOS	24
72749	BURSAL CYST NEC	24
72750	RUPTURE OF SYNOVIUM NOS	24
72751	POPLITEAL SYNOVIAL CYST	24
72759	RUPTURE OF SYNOVIUM NEC	24
72760	NONTRAUM TENDON RUPT NOS	24
72761	ROTATOR CUFF RUPTURE	24
72762	BICEPS TENDON RUPTURE	24
72763	RUPT EXTEN TENDON HAND	24
72764	RUPT FLEXOR TENDON HAND	24
72765	RUPTURE QUADRICEP TENDON	24
72766	RUPTURE PATELLAR TENDON	24
72767	RUPTURE ACHILLES TENDON	24
72768	RUPTURE TENDON FOOT NEC	24
72769	NONTRAUM TENDON RUPT NEC	24
72781	CONTRACTURE OF TENDON	24
72782	CALCIUM DEPOSIT TENDON	24
72789	SYNOV/TEND/BURSA DIS NEC	24
7279	SYNOV/TEND/BURSA DIS NOS	24
7280	INFECTIVE MYOSITIS	24
72810	MUSCULAR CALCIFICAT NOS	24
72811	PROG MYOSITIS OSSIFICANS	24
72812	TRAUM MYOSITIS OSSIFICAN	24
72813	POSTOP HETEROTOPIC CALC	24
72819	MUSCULAR CALCIFICAT NEC	24
7282	MUSC DISUSE ATROPHY NEC	24
7283	MUSCLE DISORDERS NEC	24
7284	LAXITY OF LIGAMENT	24
7285	HYPERMOBILITY SYNDROME	24
7286	CONTRACTED PALMAR FASCIA	24
72871	PLANTAR FIBROMATOSIS	24
72879	FIBROMATOSES NEC	24
72881	INTERSTITIAL MYOSITIS	24
72882	FB GRANULOMA OF MUSCLE	24
72883	NONTRAUM MUSCLE RUPTURE	24
72884	DIASTASIS OF MUSCLE	24
72885	SPASM OF MUSCLE	24
72886	NECROTIZING FASCIITIS	97
72889	MUSCLE/LIGAMENT DIS NEC	24
7289	MUSCLE/LIGAMENT DIS NOS	24
7290	RHEUMATISM NOS	24
7291	MYALGIA AND MYOSITIS NOS	24
7292	NEURALGIA/NEURITIS NOS	63
72930	PANNICULITIS, UNSP SITE	18
72931	HYPERTROPHY OF FAT PAD	18
72939	PANNICULITIS, SITE NEC	18
7294	FASCIITIS NOS	24
7295	PAIN IN LIMB	24
7296	OLD FB IN SOFT TISSUE	72
72981	SWELLING OF LIMB	24
72982	CRAMP IN LIMB	24
72989	MUSCSKEL SYMPT LIMB NEC	24
7299	SOFT TISSUE DIS NEC/NOS	24
73000	AC OSTEOMYELITIS-UNSPEC	24
73001	AC OSTEOMYELITIS-SHLDER	24
73002	AC OSTEOMYELITIS-UP/ARM	24
73003	AC OSTEOMYELITIS-FOREARM	24
73004	AC OSTEOMYELITIS-HAND	24
73005	AC OSTEOMYELITIS-PELVIS	24
73006	AC OSTEOMYELITIS-L/LEG	24
73007	AC OSTEOMYELITIS-ANKLE	24
73008	AC OSTEOMYELITIS NEC	24
73009	AC OSTEOMYELITIS-MULT	24
73010	CHR OSTEOMYELITIS-UNSP	24
73011	CHR OSTEOMYELIT-SHLDER	24
73012	CHR OSTEOMYELIT-UP/ARM	24

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
73013	CHR OSTEOMYELIT-FOREARM	24
73014	CHR OSTEOMYELIT-HAND	24
73015	CHR OSTEOMYELIT-PELVIS	24
73016	CHR OSTEOMYELIT-L/LEG	24
73017	CHR OSTEOMYELIT-ANKLE	24
73018	CHR OSTEOMYELIT NEC	24
73019	CHR OSTEOMYELIT-MULT	24
73020	OSTEOMYELITIS NOS-UNSPEC	24
73021	OSTEOMYELITIS NOS-SHLDER	24
73022	OSTEOMYELITIS NOS-UP/ARM	24
73023	OSTEOMYELIT NOS-FOREARM	24
73024	OSTEOMYELITIS NOS-HAND	24
73025	OSTEOMYELITIS NOS-PELVIS	24
73026	OSTEOMYELITIS NOS-L/LEG	24
73027	OSTEOMYELITIS NOS-ANKLE	24
73028	OSTEOMYELIT NOS-OTH SITE	24
73029	OSTEOMYELITIS NOS-MULT	24
73030	PERIOSTITIS-UNSPEC	24
73031	PERIOSTITIS-SHLDER	24
73032	PERIOSTITIS-UP/ARM	24
73033	PERIOSTITIS-FOREARM	24
73034	PERIOSTITIS-HAND	24
73035	PERIOSTITIS-PELVIS	24
73036	PERIOSTITIS-L/LEG	24
73037	PERIOSTITIS-ANKLE	24
73038	PERIOSTITIS NEC	24
73039	PERIOSTITIS-MULT	24
73070	POLIO OSTEOPATHY-UNSPEC	24
73071	POLIO OSTEOPATHY-SHLDER	24
73072	POLIO OSTEOPATHY-UP/ARM	24
73073	POLIO OSTEOPATHY-FOREARM	24
73074	POLIO OSTEOPATHY-HAND	24
73075	POLIO OSTEOPATHY-PELVIS	24
73076	POLIO OSTEOPATHY-L/LEG	24
73077	POLIO OSTEOPATHY-ANKLE	24
73078	POLIO OSTEOPATHY NEC	24
73079	POLIO OSTEOPATHY-MULT	24
73080	BONE INFECT NEC-UNSPEC	24
73081	BONE INFECT NEC-SHLDER	24
73082	BONE INFECT NEC-UP/ARM	24
73083	BONE INFECT NEC-FOREARM	24
73084	BONE INFECT NEC-HAND	24
73085	BONE INFECT NEC-PELVIS	24
73086	BONE INFECT NEC-L/LEG	24
73087	BONE INFECT NEC-ANKLE	24
73088	BONE INFECT NEC-OTH SITE	24
73089	BONE INFECT NEC-MULT	24
73090	BONE INFEC NOS-UNSP SITE	24
73091	BONE INFECT NOS-SHLDER	24
73092	BONE INFECT NOS-UP/ARM	24
73093	BONE INFECT NOS-FOREARM	24
73094	BONE INFECT NOS-HAND	24
73095	BONE INFECT NOS-PELVIS	24
73096	BONE INFECT NOS-L/LEG	24
73097	BONE INFECT NOS-ANKLE	24
73098	BONE INFECT NOS-OTH SITE	24
73099	BONE INFECT NOS-MULT	24
7310	OSTEITIS DEFORMANS NOS	24
7311	OSTEITIS DEF IN OTH DIS	24
7312	HYPERTROPH OSTEOARTHROP	24
7318	BONE INVOLV IN OTH DIS	24
7320	JUV OSTEOCHONDROS SPINE	24
7321	JUV OSTEOCHONDROS PELVIS	24
7322	FEMORAL EPIPHYSIOLYSIS	24
7323	JUV OSTEOCHONDROSIS ARM	24
7324	JUV OSTEOCHONDROSIS LEG	24
7325	JUV OSTEOCHONDROSIS FOOT	24
7326	JUV OSTEOCHONDROSIS NEC	24
7327	OSTEOCHONDRIT DISSECANS	24
7328	OSTEOCHONDROPATHY NEC	24
7329	OSTEOCHONDROPATHY NOS	24
73300	OSTEOPOROSIS NOS	24
73301	SENILE OSTEOPOROSIS	24
73302	IDIOPATHIC OSTEOPOROSIS	24
73303	DISUSE OSTEOPOROSIS	24
73309	OSTEOPOROSIS NEC	24

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
73310	PATH FX UNSPECIFIED SITE	72
73311	PATH FX HUMERUS	72
73312	PATH FX DSTL RADIUS ULNA	72
73313	PATH FX VERTEBRAE	72
73314	PATH FX NECK OF FEMUR	72
73315	PATH FX OTH SPCF PRT FMR	72
73316	PATH FX TIBIA FIBULA	72
73319	PATH FX OTH SPECIF SITE	72
73320	CYST OF BONE NOS	24
73321	SOLITARY BONE CYST	24
73322	ANEURYSMAL BONE CYST	24
73329	BONE CYST NEC	24
7333	HYPEROSTOSIS OF SKULL	24
73340	ASEPT NECROSIS BONE NOS	24
73341	ASEPTIC NECROSIS HUMERUS	24
73342	ASEPTIC NECROSIS FEMUR	24
73343	ASEPT NECRO FEMUR CONDYL	24
73344	ASEPTIC NECROSIS TALUS	24
73349	ASEPT NECROSIS BONE NEC	24
7335	OSTEITIS CONDENSANS	24
7336	TIETZE'S DISEASE	33
7337	ALGONEURODYSTROPHY	24
73381	MALUNION OF FRACTURE	72
73382	NONUNION OF FRACTURE	72
74742	PART ANOM PULM VEN CONN	36
74749	GREAT VEIN ANOMALY NEC	36
7475	UMBILICAL ARTERY ABSENCE	36
74760	UNSP PRPHERL VASC ANOMAL	36
74761	GSTRONTEST VESL ANOMALY	36
74762	RENAL VESSEL ANOMALY	36
74763	UPR LIMB VESSEL ANOMALY	36
74764	LWR LIMB VESSEL ANOMALY	36
74769	OTH SPCF PRPH VSCL ANOML	36
74781	CEREBROVASCULAR ANOMALY	11
74782	SPINAL VESSEL ANOMALY	36
74789	CIRCULATORY ANOMALY NEC	36
7479	CIRCULATORY ANOMALY NOS	11
7480	CHOANAL ATRESIA	31
7481	NOSE ANOMALY NEC	31
7482	LARYNGEAL WEB	31
7483	LARYNGOTRACH ANOMALY NEC	31
7484	CONGENITAL CYSTIC LUNG	33
7485	AGENESIS OF LUNG	33
74860	LUNG ANOMALY NOS	33
74861	CONGEN BRONCHIECTASIS	33
74869	LUNG ANOMALY NEC	33
7488	RESPIRATORY ANOMALY NEC	11
7489	RESPIRATORY ANOMALY NOS	11
74900	CLEFT PALATE NOS	31
74901	UNILAT CLEFT PALATE-COMP	31
74902	UNILAT CLEFT PALATE-INC	31
74903	BILAT CLEFT PALATE-COMPL	31
74904	BILAT CLEFT PALATE-INC	31
74910	CLEFT LIP NOS	31
74911	UNILAT CLEFT LIP-COMPL	31
74912	UNILAT CLEFT LIP-IMCOMPL	31
74913	BILAT CLEFT LIP-COMPLETE	31
74914	BILAT CLEFT LIP-INCOMPL	31
74920	CLEFT PALATE & LIP NOS	31
74921	UNIL CLEFT PALAT/LIP-COM	31
74922	UNIL CLEFT PALAT/LIP-INC	31
74923	BILAT CLFT PALAT/LIP-COM	31
74924	BILAT CLFT PALAT/LIP-INC	31
74925	CLEFT PALATE & LIP NEC	31
7500	TONGUE TIE	31
75010	TONGUE ANOMALY NOS	31
75011	AGLOSSIA	31
75012	CONG ADHESIONS OF TONGUE	31
75013	CONG FISSURE OF TONGUE	31
75015	CONG MACROGLOSSIA	31
75016	MICROGLOSSIA	31
75019	TONGUE ANOMALY NEC	31
75021	SALIVARY GLAND ABSENCE	31
75022	ACCESSORY SALIVARY GLAND	31
75023	CONG ATRESIA, SALIV DUCT	31
75024	CONG SALIVARY FISTULA	31

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
75025	CONGENITAL LIP FISTULA	31
75026	MOUTH ANOMALY NEC	11
75027	DIVERTICULUM OF PHARYNX	31
75029	PHARYNGEAL ANOMALY NEC	11
7503	CONG ESOPH FISTULA/ATRES	41
7504	ESOPHAGEAL ANOMALY NEC	41
7505	CONG PYLORIC STENOSIS	41
7506	CONGENITAL HIATUS HERNIA	41
7507	GASTRIC ANOMALY NEC	41
7508	UPPER GI ANOMALY NEC	41
7509	UPPER GI ANOMALY NOS	41
7510	MECKEL'S DIVERTICULUM	41
7511	ATRESIA SMALL INTESTINE	41
7512	ATRESIA LARGE INTESTINE	41
7513	HIRSCHSPRUNG'S DISEASE	41
7514	INTESTINAL FIXATION ANOM	41
7515	INTESTINAL ANOMALY NEC	41
75160	BILIARY & LIVER ANOM NOS	41
75161	BILIARY ATRESIA	41
75162	CONG CYSTIC LIVER DIS	41
75169	BILIARY & LIVER ANOM NEC	41
7517	PANCREAS ANOMALIES	41
7518	ANOM DIGESTIVE SYST NEC	41
7519	ANOM DIGESTIVE SYST NOS	41
7520	ANOMALIES OF OVARIES	56
75210	TUBAL/BROAD LIG ANOM NOS	56
75211	EMBRYONIC CYST OF ADNEXA	56
75219	TUBAL/BROAD LIG ANOM NEC	56
7522	DOUBLING OF UTERUS	56
7523	UTERINE ANOMALY NEC	56
75240	CERVIX/FEM GEN ANOM NOS	56
75241	EMBRYON CYST FEM GEN NEC	56
75242	IMPERFORATE HYMEN	56
75249	CERVIX/FEM GEN ANOM NEC	56
7527	INDETERMINATE SEX	53
7528	GENITAL ORGAN ANOM NEC	53
7529	GENITAL ORGAN ANOM NOS	53
7530	RENAL AGENESIS	53
75310	CYSTIC KIDNEY DISEAS NOS	53
75311	CONGENITAL RENAL CYST	53
75312	POLYCYSTIC KIDNEY NOS	53
75313	POLYCYST KID-AUTOSOM DOM	53
75314	POLYCYST KID-AUTOSOM REC	53
75315	RENAL DYSPLASIA	53
75316	MEDULLARY CYSTIC KIDNEY	53
75317	MEDULLARY SPONGE KIDNEY	53
75319	CYSTIC KIDNEY DISEAS NEC	53
7533	KIDNEY ANOMALY NEC	53
7534	URETERAL ANOMALY NEC	53
7535	BLADDER EXSTROPHY	53
7536	CONGEN URETHRAL STENOSIS	53
7537	ANOMALIES OF URACHUS	53
7538	CYSTOURETHRAL ANOM NEC	53
7539	URINARY ANOMALY NOS	53
7540	CONG SKULL/FACE/JAW DEF	24
7541	CONGENITAL TORTICOLLIS	24
7542	CONG POSTURAL DEFORMITY	24
75430	CONG HIP DISLOC, UNILAT	24
75431	CONGEN HIP DISLOC, BILAT	24
75432	CONG HIP SUBLUX, UNILAT	24
75433	CONG HIP SUBLUX, BILAT	24
75435	CONG HIP DISLOC W SUBLUX	24
75440	CONG GENU RECURVATUM	24
75441	CONG KNEE DISLOCATION	24
75442	CONGEN BOWING OF FEMUR	24
75443	CONG BOWING TIBIA/FIBULA	24
75444	CONG BOWING LEG NOS	24
75450	TALIPES VARUS	24
75451	TALIPES EQUINOVARUS	24
75452	METATARSUS PRIMUS VARUS	24
75453	METATARSUS VARUS	24
75459	CONG VARUS FOOT DEF NEC	24
75460	TALIPES VALGUS	24
75461	CONGENITAL PES PLANUS	24
75462	TALIPES CALCANEOVALGUS	24
75469	CONG VALGUS FOOT DEF NEC	24

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
75470	TALIPES NOS	24
75471	TALIPES CAVUS	24
75479	CONG FOOT DEFORM NEC	24
75481	PECTUS EXCAVATUM	11
75482	PECTUS CARINATUM	11
75489	NONTERATOGENIC ANOM NEC	24
75500	POLYDACTYLY NOS	24
75501	POLYDACTYLY, FINGERS	24
75502	POLYDACTYLY, TOES	24
75510	SYNDACTYLY, MULTIPLE/NOS	24
75511	SYNDACTYL FING-NO FUSION	24
75512	SYNDACTYL FING W FUSION	24
75513	SYNDACTYL TOE-NO FUSION	24
75514	SYNDACTYL TOE W FUSION	24
75520	REDUC DEFORM UP LIMB NOS	24
75521	TRANSVERSE DEFIC ARM	24
75522	LONGITUD DEFIC ARM NEC	24
75523	COMBIN LONGIT DEFIC ARM	24
75524	LONGITUDIN DEFIC HUMERUS	24
75525	LONGITUD DEFIC RADIOULNA	24
75526	LONGITUD DEFIC RADIUS	24
75527	LONGITUDINAL DEFIC ULNA	24
75528	LONGITUDINAL DEFIC HAND	24
75529	LONGITUD DEFIC PHALANGES	24
75530	REDUCTION DEFORM LEG NOS	24
75531	TRANSVERSE DEFIC LEG	24
75532	LONGITUDIN DEFIC LEG NEC	24
75533	COMB LONGITUDIN DEF LEG	24
75534	LONGITUDINAL DEFIC FEMUR	24
75535	TIBIOFIBULA LONGIT DEFIC	24
75536	LONGITUDINAL DEFIC TIBIA	24
75537	LONGITUDIN DEFIC FIBULA	24
75538	LONGITUDINAL DEFIC FOOT	24
75539	LONGITUD DEFIC PHALANGES	24
7554	REDUCT DEFORM LIMB NOS	24
75550	UPPER LIMB ANOMALY NOS	24
75551	CONG DEFORMITY-CLAVICLE	24
75552	CONG ELEVATION-SCAPULA	24
75553	RADIOULNAR SYNOSTOSIS	24
75554	MADELUNG'S DEFORMITY	24
75555	ACROCEPHALOSYNDACTYLY	24
75556	ACCESSORY CARPAL BONES	24
75557	MACRODACTYLIA (FINGERS)	24
75558	CONGENITAL CLEFT HAND	24
75559	UPPER LIMB ANOMALY NEC	24
75560	LOWER LIMB ANOMALY NOS	24
75561	CONGENITAL COXA VALGA	24
75562	CONGENITAL COXA VARA	24
75563	CONG HIP DEFORMITY NEC	24
75564	CONG KNEE DEFORMITY	24
75565	MACRODACTYLIA OF TOES	24
75566	ANOMALIES OF TOES NEC	24
75567	ANOMALIES OF FOOT NEC	24
75569	LOWER LIMB ANOMALY NEC	24
7558	CONGEN LIMB ANOMALY NEC	24
7559	CONGEN LIMB ANOMALY NOS	24
7560	ANOMAL SKULL/FACE BONES	24
75610	ANOMALY OF SPINE NOS	24
75611	LUMBOSACR SPONDYLOLYSIS	24
75612	SPONDYLOLISTHESIS	24
75613	CONG ABSENCE OF VERTEBRA	24
75614	HEMIVERTEBRA	24
75615	CONGEN FUSION OF SPINE	24
75616	KLIPPEL-FEIL SYNDROME	24
75617	SPINA BIFIDA OCCULTA	63
75619	ANOMALY OF SPINE NEC	24
7562	CERVICAL RIB	24
7563	RIB & STERNUM ANOMAL NEC	11
7564	CHONDRODYSTROPHY	24
75650	OSTEODYSTROPHY NOS	24
75651	OSTEOGENESIS IMPERFECTA	24
75652	OSTEOPETROSIS	24
75653	OSTEOPOIKILOSIS	24
75654	POLYOSTOTIC FIBROS DYSPL	24
75655	CHONDROECTODERM DYSPLAS	24
75656	MULT EPIPHYSEAL DYSPLAS	24

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
75659	OSTEODYSTROPHY NEC	24
7566	ANOMALIES OF DIAPHRAGM	11
75681	ABSENCE OF MUSCLE/TENDON	24
75682	ACCESSORY MUSCLE	24
75683	EHLERS-DANLOS SYNDROME	24
75689	SOFT TISSUE ANOMALY NEC	24
7569	MUSCULOSKEL ANOM NEC/NOS	24
7570	HEREDITARY EDEMA OF LEGS	18
7571	ICHTHYOSIS CONGENITA	18
7572	DERMATOGLYPHIC ANOMALIES	18
75731	CONG ECTODERMAL DYSPLAS	18
75732	VASCULAR HAMARTOMAS	18
75733	CONG SKIN PIGMENT ANOMAL	18
75739	SKIN ANOMALY NEC	18
7574	HAIR ANOMALIES NEC	18
7575	NAIL ANOMALIES NEC	18
7576	BREAST ANOMALIES NEC	18
7578	OTH INTEGUMENT ANOMALIES	18
7579	INTEGUMENT ANOMALY NOS	18
7580	DOWN'S SYNDROME	91
7581	PATAU'S SYNDROME	91
7582	EDWARDS' SYNDROME	91
7583	AUTOSOMAL DELETION SYND	91
7584	BALANCE AUTOSOM TRANSLOC	11
7585	AUTOSOMAL ANOMALIES NEC	11
7586	GONADAL DYSGENESIS	53
7587	KLINEFELTER'S SYNDROME	53
7589	CHROMOSOME ANOMALY NOS	57
7590	ANOMALIES OF SPLEEN	86
7591	ADRENAL GLAND ANOMALY	82
7592	ENDOCRINE ANOMALY NEC	82
7593	SITUS INVERSUS	41
7594	CONJOINED TWINS	57
7595	TUBEROUS SCLEROSIS	63
7596	HAMARTOSES NEC	18
7597	MULT CONGEN ANOMAL NEC	57
75981	PRADER-WILLI SYNDROME	57
75982	MARFAN SYNDROME	57
75983	FRAGILE X SYNDROME	82
75989	SPECFIED CONG ANOMAL NEC	57
7599	CONGENITAL ANOMALY NOS	57
7600	MATERN HYPERTEN AFF NB	57
7601	MATERN URINE DIS AFF NB	57
7602	MATERNAL INFEC AFF NB	57
7603	MATERN CARDIORESP AFF NB	57
7604	MATERN NUTRIT DIS AFF NB	57
7605	MATERNAL INJURY AFF NB	57
7606	SURG OP ON MOTHER AFF NB	57
76070	NOXIOUS SUBST NOS AFF NB	57
76071	MATERNAL ALCOHOL AFF NB	57
76072	MATERNAL NARCOTIC AFF NB	57
76073	MATERNAL HALLUCIN AFF NB	57
76074	MATERNAL ANTI-INF AFF NB	57
76075	COCAINE - NXS INFL FETUS	57
76076	FTS/NB AFCTD MTRNL DES	56
76079	NOXIOUS SUBST NEC AFF NB	57
7608	MATERNAL COND NEC AFF NB	57
7609	MATERNAL COND NOS AFF NB	57
7610	INCOMPETNT CERVIX AFF NB	57
7611	PREMAT RUPT MEMB AFF NB	57
7612	OLIGOHYDRAMNIOS AFF NB	57
7613	POLYHYDRAMNIOS AFF NB	57
7614	ECTOPIC PREGNANCY AFF NB	57
7615	MULT PREGNANCY AFF NB	57
7616	MATERNAL DEATH AFF NB	57
7617	ANTEPART MALPRES AFF NB	57
7618	MATERN COMPL NEC AFF NB	57
7619	MATERN COMPL NOS AFF NB	57
7620	PLACENTA PREVIA AFF NB	57
7621	PLACENTA HEM NEC AFF NB	57
7622	ABN PLAC NEC/NOS AFF NB	57
7623	PLACENT TRANSFUSION SYN	57
7624	PROLAPSED CORD AFF NB	57
7625	OTH UMBIL CORD COMPRESS	57
7626	UMBIL COND NEC AFF NB	57
7627	CHORIOAMNIONITIS AFF NB	57

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
7628	ABN AMNION NEC AFF NB	57
7629	ABN AMNION NOS AFF NB	57
7630	BREECH DEL/EXTRAC AFF NB	57
7631	MALPOS/DISPRO NEC AFF NB	57
7632	FORCEPS DELIVERY AFF NB	57
7633	VACUUM EXTRAC DEL AFF NB	57
7634	CESAREAN DELIVERY AFF NB	57
7635	MAT ANESTH/ANALG AFF NB	57
7636	PRECIPITATE DEL AFF NB	57
7637	ABN UTERINE CONTR AFF NB	57
7638	COMPL DELIV NEC AFF NB	57
7639	COMPL DELIV NOS AFF NB	57
76400	LIGHT-FOR-DATES WTNOS	57
76401	LIGHT-FOR-DATES <500G	57
76402	LT-FOR-DATES 500-749G	57
76403	LT-FOR-DATES 750-999G	57
76404	LT-FOR-DATES 1000-1249G	57
76405	LT-FOR-DATES 1250-1499G	57
76406	LT-FOR-DATES 1500-1749G	57
76407	LT-FOR-DATES 1750-1999G	57
76408	LT-FOR-DATES 2000-2499G	57
76409	LT-FOR-DATES 2500+G	57
76410	LT-FOR-DATE W/MAL WTNOS	57
76411	LT-FOR-DATE W/MAL <500G	57
76412	LT-DATE W/MAL 500-749G	57
76413	LT-DATE W/MAL 750-999G	57
76414	LT-DATE W/MAL 1000-1249G	57
76415	LT-DATE W/MAL 1250-1499G	57
76416	LT-DATE W/MAL 1500-1749G	57
76417	LT-DATE W/MAL 1750-1999G	57
76418	LT-DATE W/MAL 2000-2499G	57
76419	LT-FOR-DATE W/MAL 2500+G	57
76420	FETAL MALNUTRITION WTNOS	57
76421	FETAL MALNUTRITION <500G	57
76422	FETAL MALNUTR 500-749G	57
76423	FETAL MAL 750-999G	57
76424	FETAL MAL 1000-1249G	57
76425	FETAL MAL 1250-1499G	57
76426	FETAL MAL 1500-1749G	57
76427	FETAL MALNUTR 1750-1999G	57
76428	FETAL MALNUTR 2000-2499G	57
76429	FETAL MALNUTR 2500+G	57
76490	FET GROWTH RETARD WTNOS	57
76491	FET GROWTH RETARD <500G	57
76492	FET GROWTH RET 500-749G	57
76493	FET GROWTH RET 750-999G	57
76494	FET GRWTH RET 1000-1249G	57
76495	FET GRWTH RET 1250-1499G	57
76496	FET GRWTH RET 1500-1749G	57
76497	FET GRWTH RET 1750-1999G	57
76498	FET GRWTH RET 2000-2499G	57
76499	FET GROWTH RET 2500+G	57
76500	EXTREME IMMATUR WTNOS	57
76501	EXTREME IMMATUR <500G	57
76502	EXTREME IMMATUR 500-749G	57
76503	EXTREME IMMATUR 750-999G	57
76504	EXTREME IMMAT 1000-1249G	57
76505	EXTREME IMMAT 1250-1499G	57
76506	EXTREME IMMAT 1500-1749G	57
76507	EXTREME IMMAT 1750-1999G	57
76508	EXTREME IMMAT 2000-2499G	57
76509	EXTREME IMMAT 2500+G	57
76510	PRETERM INFANT NEC WTNOS	57
76511	PRETERM NEC <500G	57
76512	PRETERM NEC 500-749G	57
76513	PRETERM NEC 750-999G	57
76514	PRETERM NEC 1000-1249G	57
76515	PRETERM NEC 1250-1499G	57
76516	PRETERM NEC 1500-1749G	57
76517	PRETERM NEC 1750-1999G	57
76518	PRETERM NEC 2000-2499G	57
76519	PRETERM NEC 2500+G	57
7660	EXCEPTIONALLY LARGE BABY	57
7661	HEAVY-FOR-DATE INFAN NEC	57
7662	POST-TERM INFANT NOS	57
7670	CEREBRAL HEM AT BIRTH	57

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
7671	SCALP INJURY AT BIRTH	57
7672	CLAVICLE FX AT BIRTH	57
7673	BONE INJURY NEC AT BIRTH	57
7674	SPINAL CORD INJ AT BIRTH	57
7675	FACIAL NERVE INJ-BIRTH	57
7676	BRACH PLEXUS INJ-BIRTH	57
7677	NERVE INJ NEC AT BIRTH	57
7678	BIRTH TRAUMA NEC	57
7679	BIRTH TRAUMA NOS	57
7680	FETAL DEATH-ANOXIA NOS	57
7681	FET DEATH-ANOXIA DUR LAB	57
7682	FET DISTRESS BEFOR LABOR	57
7683	FETAL DISTRESS DUR LABOR	57
7684	FETAL DISTRESS NOS	57
7685	SEVERE BIRTH ASPHYXIA	57
7686	MILD/MOD BIRTH ASPHYXIA	57
7689	BIRTH ASPHYXIA NOS	57
769	RESPIRATORY DISTRESS SYN	57
7700	CONGENITAL PNEUMONIA	57
7701	MECONIUM ASPIRATN SYNDRM	57
7702	NB INTERSTIT EMPHYSEMA	57
7703	NB PULMONARY HEMORRHAGE	57
7704	PRIMARY ATELECTASIS	57
7705	NB ATELECTASIS NEC/NOS	57
7706	NB TRANSITORY TACHYPNEA	57
7707	PERINATAL CHR RESP DIS	57
7708	POST-BIRTH RESP PROB NEC	57
7709	NB RESPIRATORY COND NOS	57
7710	CONGENITAL RUBELLA	57
7711	CONG CYTOMEGALOVIRUS INF	57
7712	CONGENITAL INFEC NEC	57
7713	TETANUS NEONATORUM	57
7714	OMPHALITIS OF NEWBORN	57
7715	NEONATAL INFEC MASTITIS	57
7716	NEONATAL CONJUNCTIVITIS	57
7717	NEONATAL CANDIDA INFECT	57
7718	PERINATAL INFECTION NEC	57
7720	FETAL BLOOD LOSS NEC	57
7721	NB INTRAVENTRICULAR HEM	57
7722	NB SUBARACHNOID HEMORR	57
7723	POST-BIRTH UMBIL HEMORR	57
7724	NB GI HEMORRHAGE	57
7725	NB ADRENAL HEMORRHAGE	57
7726	NB CUTANEOUS HEMORRHAGE	57
7728	NEONATAL HEMORRHAGE NEC	57
7729	NEONATAL HEMORRHAGE NOS	57
7730	NB HEMOLYT DIS:RH ISOIMM	57
7731	NB HEMOLYT DIS-ABO ISOIM	57
7732	NB HEMOLYT DIS-ISOIM NEC	57
7733	HYDROPS FETALIS:ISOIMM	57
7734	NB KERNICTERUS:ISOIMMUN	57
7735	NB LATE ANEMIA:ISOIMMUN	57
7740	PERINAT JAUND-HERED ANEM	57
7741	PERINAT JAUND:HEMOLYSIS	57
7742	NEONAT JAUND PRETERM DEL	57
77430	DELAY CONJUGAT JAUND NOS	57
77431	NEONAT JAUND IN OTH DIS	57
77439	DELAY CONJUGAT JAUND NEC	57
7744	FETAL/NEONATAL HEPATITIS	57
7745	PERINATAL JAUNDICE NEC	57
7746	FETAL/NEONATAL JAUND NOS	57
7747	NB KERNICTERUS	57
7750	INFANT DIABET MOTHER SYN	57
7751	NEONAT DIABETES MELLITUS	57
7752	NEONAT MYASTHENIA GRAVIS	57
7753	NEONATAL THYROTOXICOSIS	57
7754	HYPOCALCEM/HYPOMAGNES NB	57
7755	NEONATAL DEHYDRATION	57
7756	NEONATAL HYPOGLYCEMIA	57
7757	LATE METAB ACIDOSIS NB	57
7758	TRANSIENT MET DIS NB NEC	57
7759	TRANSIENT MET DIS NB NOS	57
7760	NB HEMORRHAGIC DISEASE	57
7761	NEONATAL THROMBOCYTOPEN	57
7762	DISSEM INTRAVASC COAG NB	57
7763	OTH NEONATAL COAG DIS	57

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
7764	POLYCYTHEMIA NEONATORUM	57
7765	CONGENITAL ANEMIA	57
7766	ANEMIA OF PREMATURITY	57
7767	NEONATAL NEUTROPENIA	57
7768	TRANSIENT HEMAT DIS NEC	57
7769	NB HEMATOLOGICAL DIS NOS	57
7771	MECONIUM OBSTRUCTION	57
7772	INTEST OBST-INSPISS MILK	57
7773	SWALLOWED BLOOD SYNDROME	57
7774	TRANSITORY ILEUS OF NB	57
7775	NECROT ENTEROCOLITIS NB	57
7776	PERINATAL INTEST PERFOR	57
7778	PERINAT GI SYS DIS NEC	57
7779	PERINAT GI SYS DIS NOS	57
7780	HYDROPS FETALIS NO ISOIM	57
7781	SCLEREMA NEONATORUM	57
7782	NB COLD INJURY SYNDROME	57
7783	NB HYPOTHERMIA NEC	57
7784	NB TEMP REGULAT DIS NEC	57
7785	EDEMA OF NEWBORN NEC/NOS	57
7786	CONGENITAL HYDROCELE	57
7787	NB BREAST ENGORGEMENT	57
7788	NB INTEGUMENT COND NEC	57
7789	NB INTEGUMENT COND NOS	57
7790	CONVULSIONS IN NEWBORN	57
7791	NB CEREB IRRIT NEC/NOS	57
7792	CNS DYSFUNCTION SYN NB	57
7793	NB FEEDING PROBLEMS	57
7794	NB DRUG REACTION/INTOXIC	57
7795	NB DRUG WITHDRAWAL SYNDR	57
*7796	TERMINATION OF PREGNANCY	
7798	PERINATAL CONDITION NEC	57
7799	PERINATAL CONDITION NOS	57
78001	COMA	78
78002	TRANS ALTER AWARENESS	63
78003	PERSISTENT VEGTV STATE	78
78009	OTHER ALTER CONSCIOUSNES	63
7801	HALLUCINATIONS	91
7802	SYNCOPE AND COLLAPSE	63
7804	DIZZINESS AND GIDDINESS	11
78050	SLEEP DISTURBANCE NOS	91
78051	INSOMNIA W SLEEP APNEA	63
78052	INSOMNIA NEC	91
78053	HYPERSOMNI W SLEEP APNEA	63
78054	HYPERSOMNIA NEC	91
78055	IRREG SLEEP-WAKE RHY NOS	91
78056	SLEEP STAGE DYSFUNCTIONS	91
78057	OTH UNSPCF SLEEP APNEA	91
78059	SLEEP DISTURBANCES NEC	91
7806	FEVER	97
7807	MALAISE AND FATIGUE	11
7808	HYPERHIDROSIS	99
7809	GENERAL SYMPTOMS NEC	11
7810	ABN INVOLUN MOVEMENT NEC	63
7811	SMELL & TASTE DISTURB	63
7812	ABNORMALITY OF GAIT	63
7813	LACK OF COORDINATION	11
7814	TRANSIENT LIMB PARALYSIS	63
7815	CLUBBING OF FINGERS	33
7816	MENINGISMUS	78
7817	TETANY	82
7818	NEUROLOGIC NEGLECT SYNDR	63
7819	NERV/MUSCULSKEL SYM NEC	11
7820	SKIN SENSATION DISTURB	11
7821	NONSPECIF SKIN ERUPT NEC	18
7822	LOCAL SUPRFICIAL SWELLNG	11
7823	EDEMA	11
7824	JAUNDICE NOS	41
7825	CYANOSIS	36
78261	PALLOR	11
78262	FLUSHING	11
7827	SPONTANEOUS ECCHYMOSES	86
7828	CHANGES IN SKIN TEXTURE	11
7829	INTEGUMENT TISS SYMP NEC	11
7830	ANOREXIA	41
7831	ABNORMAL WEIGHT GAIN	82

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
7832	ABNORMAL LOSS OF WEIGHT	82
7833	FEEDING PROBLEM	41
7834	LACK NORM PHYSIOL DEVEL	82
7835	POLYDIPSIA	82
7836	POLYPHAGIA	82
7839	NUTR/METAB/DEVEL SYM NEC	82
7840	HEADACHE	63
7841	THROAT PAIN	11
7842	SWELLING IN HEAD & NECK	11
7843	APHASIA	63
78440	VOICE DISTURBANCE NOS	11
78441	APHONIA	11
78449	VOICE DISTURBANCE NEC	11
7845	SPEECH DISTURBANCE NEC	11
78460	SYMBOLIC DYSFUNCTION NOS	91
78461	ALEXIA AND DYSLEXIA	91
78469	SYMBOLIC DYSFUNCTION NEC	91
7847	EPISTAXIS	31
7848	HEMORRHAGE FROM THROAT	41
7849	SYMP INVOL HEAD/NECK NEC	11
7850	TACHYCARDIA NOS	36
7851	PALPITATIONS	36
7852	CARDIAC MURMURS NEC	36
7853	ABNORM HEART SOUNDS NEC	36
7854	GANGRENE	36
78550	SHOCK NOS	78
78551	CARDIOGENIC SHOCK	78
78559	SHOCK W/O TRAUMA NEC	97
7856	ENLARGEMENT LYMPH NODES	86
7859	CARDIOVAS SYS SYMP NEC	36
78600	RESPIRATORY ABNORM NOS	33
78601	HYPERVENTILATION	11
78602	ORTHOPNEA	36
78609	RESPIRATORY ABNORM NEC	33
7861	STRIDOR	33
7862	COUGH	31
7863	HEMOPTYSIS	33
7864	ABNORMAL SPUTUM	11
78650	CHEST PAIN NOS	36
78651	PRECORDIAL PAIN	36
78652	PAINFUL RESPIRATION	36
78659	CHEST PAIN NEC	36
7866	CHEST SWELLING/MASS/LUMP	24
7867	ABNORMAL CHEST SOUNDS	11
7868	HICCOUGH	11
7869	RESP SYS/CHEST SYMP NEC	11
7870	NAUSEA AND VOMITING*	41
78701	NAUSEA WITH VOMITING	41
78702	NAUSEA ALONE	41
78703	VOMITING ALONE	41
7871	HEARTBURN	41
7872	DYSPHAGIA	41
7873	FLATUL/ERUCTAT/GAS PAIN	41
7874	VISIBLE PERISTALSIS	41
7875	ABNORMAL BOWEL SOUNDS	41
7876	INCONTINENCE OF FECES	41
7877	ABNORMAL FECES	41
78791	DIARRHEA	41
78799	DIGESTVE SYST SYMPTM NEC	41
7880	RENAL COLIC	53
7881	DYSURIA	53
78820	RETENTION URINE NOS	53
78821	INCMPLET BLDDER EMPTYING	53
78829	OTH SPCF RETENTION URINE	53
7883	INCONTINENCE OF URINE*	53
78830	URINARY INCONTINENCE NOS	53
78831	URGE INCONTINENCE	53
78832	STRESS INCONTINENCE MALE	53
78833	MIXED INCONTINENCE	53
78834	INCONTNCE WO SENSR AWARE	53
78835	POST-VOID DRIBBLING	53
78836	NOCTURNAL ENURESIS	53
78837	CONTINUOUS LEAKAGE	53
78839	OTH URINRY INCONTINENCE	53
78841	URINARY FREQUENCY	53
78842	POLYURIA	53

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
78843	NOCTURIA	53
7885	OLIGURIA & ANURIA	53
78861	SPLITTING URINARY STREAM	53
78862	SLOWING URINARY STREAM	53
78869	OTH ABNORMALT URINATION	53
7887	URETHRAL DISCHARGE	97
7888	EXTRAVASATION OF URINE	53
7889	URINARY SYS SYMPTOM NEC	53
78900	ABDMNAL PAIN UNSPCF SITE	41
78901	ABDMNAL PAIN RT UPR QUAD	41
78902	ABDMNAL PAIN LFT UP QUAD	41
78903	ABDMNAL PAIN RT LWR QUAD	41
78904	ABDMNAL PAIN LT LWR QUAD	41
78905	ABDMNAL PAIN PERIUMBILIC	41
78906	ABDMNAL PAIN EPIGASTRIC	41
78907	ABDMNAL PAIN GENERALIZED	41
78909	ABDMNAL PAIN OTH SPCF ST	41
7891	HEPATOMEGALY	41
7892	SPLENOMEGALY	86
78930	ABDMNAL MASS UNSPCF SITE	41
78931	ABDMNAL MASS RT UPR QUAD	41
78932	ABDMNAL MASS LFT UP QUAD	41
78933	ABDMNAL MASS RT LWR QUAD	41
78934	ABDMNAL MASS LT LWR QUAD	41
78935	ABDMNAL MASS PERIUMBILIC	41
78936	ABDMNAL MASS EPIGASTRIC	41
78937	ABDMNAL MASS GENERALIZED	41
78939	ABDMNAL MASS OTH SPCF ST	41
78940	ABDMNAL RGDT UNSPCF SITE	41
78941	ABDMNAL RGDT RT UPR QUAD	41
78942	ABDMNAL RGDT LFT UP QUAD	41
78943	ABDMNAL RGDT RT LWR QUAD	41
78944	ABDMNAL RGDT LT LWR QUAD	41
78945	ABDMNAL RGDT PERIUMBILIC	41
78946	ABDMNAL RGDT EPIGASTRIC	41
78947	ABDMNAL RGDT GENERALIZED	41
78949	ABDMNAL RGDT OTH SPCF ST	41
7895	ASCITES	41
78960	ABDMNAL TNDR UNSPCF SITE	41
78961	ABDMNAL TNDR RT UPR QUAD	41
78962	ABDMNAL TNDR LFT UP QUAD	41
78963	ABDMNAL TNDR RT LWR QUAD	41
78964	ABDMNAL TNDR LT LWR QUAD	41
78965	ABDMNAL TNDR PERIUMBILIC	41
78966	ABDMNAL TNDR EPIGASTRIC	41
78967	ABDMNAL TNDR GENERALIZED	41
78969	ABDMNAL TNDR OTH SPCF ST	41
7899	ABDOMEN/PELVIS SYMP NEC	11
7900	ABNORM RED BLOOD CELL	86
7901	ELEVATED SEDIMENT RATE	11
7902	ABN GLUCOSE TOLERAN TEST	11
7903	EXCESS BLOOD-ALCOHOL LEV	91
7904	ELEV TRANSAMINASE/LDH	11
7905	ABN SERUM ENZY LEVEL NEC	11
7906	ABN BLOOD CHEMISTRY NEC	11
7907	BACTEREMIA	97
7908	VIREMIA NOS	97
79091	ABNRML ART BLOOD GASES	11
79092	ABNRML COAGULTION PRFILE	11
79093	ELVTD PRSTATE SPCF ANTGN	11
79099	OTH NSPCF FINDING BLOOD	11
7910	PROTEINURIA	53
7911	CHYLURIA	78
7912	HEMOGLOBINURIA	53
7913	MYOGLOBINURIA	53
7914	BILIURIA	53
7915	GLYCOSURIA	53
7916	ACETONURIA	53
7917	OTH CELLS/CASTS IN URINE	53
7919	ABN URINE FINDINGS NEC	53
7920	ABN FND-CEREBROSPINAL FL	11
7921	ABN FIND-STOOL CONTENTS	11
7922	ABN FINDINGS-SEMEN	53
7923	ABN FIND-AMNIOTIC FLUID	57
7924	ABN FINDINGS-SALIVA	11
7929	ABN FIND-BODY SUBST NEC	11

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
7930	ABN FINDING-SKULL & HEAD	11
7931	ABN FINDINGS-LUNG FIELD	11
7932	ABN FD-INTRATHOR ORG NEC	11
7933	ABN FIND-BILIARY TRACT	41
7934	ABN FINDINGS-GI TRACT	11
7935	ABN FINDINGS-GU ORGANS	53
7936	ABN FIND-ABDOMINAL AREA	11
7937	ABN FIND-MUSCULOSKEL SYS	11
7938	ABNORMAL FINDINGS-BREAST	18
7939	ABN FIND-BODY STRUCT NEC	11
79400	ABN CNS FUNCT STUDY NOS	11
79401	ABNORM ECHOENCEPHALOGRAM	11
79402	ABN ELECTROENCEPHALOGRAM	11
79409	ABN CNS FUNCT STUDY NEC	11
79410	ABN STIMUL RESPONSE NOS	11
79411	ABN RETINAL FUNCT STUDY	68
79412	ABNORM ELECTRO-OCULOGRAM	68
79413	ABNORMAL VEP	68
79414	ABN OCULOMOTOR STUDIES	68
79415	ABN AUDITORY FUNCT STUDY	31
79416	ABN VESTIBULAR FUNC STUD	11
79417	ABNORM ELECTROMYOGRAM	24
79419	ABN PERIPH NERV STUD NEC	11
7942	ABN PULMONARY FUNC STUDY	11
79430	ABN CARDIOVASC STUDY NOS	11
79431	ABNORM ELECTROCARDIOGRAM	11
79439	ABN CARDIOVASC STUDY NEC	11
7944	ABN KIDNEY FUNCT STUDY	53
7945	ABN THYROID FUNCT STUDY	82
7946	ABN ENDOCRINE STUDY NEC	82
7947	ABN BASAL METABOL STUDY	82
7948	ABN LIVER FUNCTION STUDY	41
7949	ABN FUNCTION STUDY NEC	53
7950	ABN PAP SMEAR-CERVIX	56
7951	ABN PAP SMEAR-OTH SITE	56
7952	ABN CHROMOSOMAL ANALYSIS	57
7953	POSITIVE CULTURE FINDING	97
7954	ABN HISTOLOGIC FIND NEC	11
7955	TUBERCULIN TEST REACTION	11
7956	FALSE POS SERO TEST-SYPH	11
79571	NONSPCF SERLGC EVDNC HIV	86
79579	OTH UNSPCF NSPF IMUN FND	86
7960	ABN TOXICOLOGIC FINDING	11
7961	ABNORMAL REFLEX	11
7962	ELEV BL PRES W/O HYPERTN	36
7963	LOW BLOOD PRESS READING	36
7964	ABN CLINICAL FINDING NEC	11
7969	ABNORMAL FINDINGS NEC	11
797	SENILITY W/O PSYCHOSIS	91
7980	SUDDEN INFANT DEATH SYND	99
7981	INSTANTANEOUS DEATH	99
7982	DEATH WITHIN 24 HR SYMPT	99
7989	UNATTENDED DEATH	99
7990	ASPHYXIA	78
7991	RESPIRATORY ARREST	78
7992	NERVOUSNESS	91
7993	DEBILITY NOS	11
7994	CACHEXIA	41
7998	ILL-DEFINE CONDITION NEC	11
7999	UNKN CAUSE MORB/MORT NEC	11
80000	CLOSED SKULL VAULT FX	72
80001	CL SKULL VLT FX W/O COMA	72
80002	CL SKULL VLT FX-BRF COMA	72
80003	CL SKULL VLT FX-MOD COMA	72
80004	CL SKL VLT FX-PROLN COMA	72
80005	CL SKUL VLT FX-DEEP COMA	72
80006	CL SKULL VLT FX-COMA NOS	72
80009	CL SKL VLT FX-CONCUS NOS	72
80010	CL SKL VLT FX/CEREBR LAC	72
80011	CL SKULL VLT FX W/O COMA	72
80012	CL SKULL VLT FX-BRF COMA	72
80013	CL SKULL VLT FX-MOD COMA	72
80014	CL SKL VLT FX-PROLN COMA	72
80015	CL SKUL VLT FX-DEEP COMA	72
80016	CL SKULL VLT FX-COMA NOS	72
80019	CL SKL VLT FX-CONCUS NOS	72

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
80020	CL SKL VLT FX/MENING HEM	72
80021	CL SKULL VLT FX W/O COMA	72
80022	CL SKULL VLT FX-BRF COMA	72
80023	CL SKULL VLT FX-MOD COMA	72
80024	CL SKL VLT FX-PROLN COMA	72
80025	CL SKUL VLT FX-DEEP COMA	72
80026	CL SKULL VLT FX-COMA NOS	72
80029	CL SKL VLT FX-CONCUS NOS	72
80030	CL SKULL VLT FX/HEM NEC	72
80031	CL SKULL VLT FX W/O COMA	72
80032	CL SKULL VLT FX-BRF COMA	72
80033	CL SKULL VLT FX-MOD COMA	72
80034	CL SKL VLT FX-PROLN COMA	72
80035	CL SKUL VLT FX-DEEP COMA	72
80036	CL SKULL VLT FX-COMA NOS	72
80039	CL SKL VLT FX-CONCUS NOS	72
80040	CL SKL VLT FX/BR INJ NEC	72
80041	CL SKULL VLT FX W/O COMA	72
80042	CL SKULL VLT FX-BRF COMA	72
80043	CL SKULL VLT FX-MOD COMA	72
80044	CL SKL VLT FX-PROLN COMA	72
80045	CL SKUL VLT FX-DEEP COMA	72
80046	CL SKULL VLT FX-COMA NOS	72
80049	CL SKL VLT FX-CONCUS NOS	72
80050	OPN SKULL VAULT FRACTURE	72
80051	OPN SKUL VLT FX W/O COMA	72
80052	OPN SKUL VLT FX-BRF COMA	72
80053	OPN SKUL VLT FX-MOD COMA	72
80054	OPN SKL VLT FX-PROLN COM	72
80055	OPN SKL VLT FX-DEEP COMA	72
80056	OPN SKUL VLT FX-COMA NOS	72
80059	OP SKL VLT FX-CONCUS NOS	72
80060	OPN SKL VLT FX/CEREB LAC	72
80061	OPN SKUL VLT FX W/O COMA	72
80062	OPN SKUL VLT FX-BRF COMA	72
80063	OPN SKUL VLT FX-MOD COMA	72
80064	OPN SKL VLT FX-PROLN COM	72
80065	OPN SKL VLT FX-DEEP COMA	72
80066	OPN SKUL VLT FX-COMA NOS	72
80069	OP SKL VLT FX-CONCUS NOS	72
80070	OPN SKL VLT FX/MENIN HEM	72
80071	OPN SKUL VLT FX W/O COMA	72
80072	OPN SKUL VLT FX-BRF COMA	72
80073	OPN SKUL VLT FX-MOD COMA	72
80074	OPN SKL VLT FX-PROLN COM	72
80075	OPN SKL VLT FX-DEEP COMA	72
80076	OPN SKUL VLT FX-COMA NOS	72
80079	OP SKL VLT FX-CONCUS NOS	72
80080	OPN SKULL VLT FX/HEM NEC	72
80081	OPN SKUL VLT FX W/O COMA	72
80082	OPN SKUL VLT FX-BRF COMA	72
80083	OPN SKUL VLT FX-MOD COMA	72
80084	OPN SKL VLT FX-PROLN COM	72
80085	OPN SKL VLT FX-DEEP COMA	72
80086	OPN SKUL VLT FX-COMA NOS	72
80089	OP SKL VLT FX-CONCUS NOS	72
80090	OP SKL VLT FX/BR INJ NEC	72
80091	OPN SKUL VLT FX W/O COMA	72
80092	OPN SKUL VLT FX-BRF COMA	72
80093	OPN SKUL VLT FX-MOD COMA	72
80094	OPN SKL VLT FX-PROLN COM	72
80095	OP SKUL VLT FX-DEEP COMA	72
80096	OPN SKUL VLT FX-COMA NOS	72
80099	OP SKL VLT FX-CONCUS NOS	72
80100	CLOS SKULL BASE FRACTURE	72
80101	CL SKUL BASE FX W/O COMA	72
80102	CL SKUL BASE FX-BRF COMA	72
80103	CL SKUL BASE FX-MOD COMA	72
80104	CL SKL BASE FX-PROL COMA	72
80105	CL SKL BASE FX-DEEP COMA	72
80106	CL SKUL BASE FX-COMA NOS	72
80109	CL SKULL BASE FX-CONCUSS	72
80110	CL SKL BASE FX/CEREB LAC	72
80111	CL SKUL BASE FX W/O COMA	72
80112	CL SKUL BASE FX-BRF COMA	72
80113	CL SKUL BASE FX-MOD COMA	72

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
80114	CL SKL BASE FX-PROL COMA	72
80115	CL SKL BASE FX-DEEP COMA	72
80116	CL SKUL BASE FX-COMA NOS	72
80119	CL SKULL BASE FX-CONCUSS	72
80120	CL SKL BASE FX/MENIN HEM	72
80121	CL SKUL BASE FX W/O COMA	72
80122	CL SKUL BASE FX/BRF COMA	72
80123	CL SKUL BASE FX-MOD COMA	72
80124	CL SKL BASE FX-PROL COMA	72
80125	CL SKL BASE FX-DEEP COMA	72
80126	CL SKUL BASE FX-COMA NOS	72
80129	CL SKULL BASE FX-CONCUSS	72
80130	CL SKULL BASE FX/HEM NEC	72
80131	CL SKUL BASE FX W/O COMA	72
80132	CL SKUL BASE FX-BRF COMA	72
80133	CL SKUL BASE FX-MOD COMA	72
80134	CL SKL BASE FX-PROL COMA	72
80135	CL SKL BASE FX-DEEP COMA	72
80136	CL SKUL BASE FX-COMA NOS	72
80139	CL SKULL BASE FX-CONCUSS	72
80140	CL SK BASE FX/BR INJ NEC	72
80141	CL SKUL BASE FX W/O COMA	72
80142	CL SKUL BASE FX-BRF COMA	72
80143	CL SKUL BASE FX-MOD COMA	72
80144	CL SKL BASE FX-PROL COMA	72
80145	CL SKL BASE FX-DEEP COMA	72
80146	CL SKUL BASE FX-COMA NOS	72
80149	CL SKULL BASE FX-CONCUSS	72
80150	OPEN SKULL BASE FRACTURE	72
80151	OPN SKL BASE FX W/O COMA	72
80152	OPN SKL BASE FX-BRF COMA	72
80153	OPN SKL BASE FX-MOD COMA	72
80154	OP SKL BASE FX-PROL COMA	72
80155	OP SKL BASE FX-DEEP COMA	72
80156	OPN SKL BASE FX-COMA NOS	72
80159	OPN SKUL BASE FX-CONCUSS	72
80160	OP SKL BASE FX/CEREB LAC	72
80161	OPN SKL BASE FX W/O COMA	72
80162	OPN SKL BASE FX-BRF COMA	72
80163	OPN SKL BASE FX-MOD COMA	72
80164	OP SKL BASE FX-PROL COMA	72
80165	OP SKL BASE FX-DEEP COMA	72
80166	OPN SKL BASE FX-COMA NOS	72
80169	OPN SKUL BASE FX-CONCUSS	72
80170	OP SKL BASE FX/MENIN HEM	72
80171	OPN SKL BASE FX W/O COMA	72
80172	OPN SKL BASE FX-BRF COMA	72
80173	OPN SKL BASE FX-MOD COMA	72
80174	OP SKL BASE FX-PROL COMA	72
80175	OP SKL BASE FX-DEEP COMA	72
80176	OPN SKL BASE FX-COMA NOS	72
80179	OPN SKUL BASE FX-CONCUSS	72
80180	OPN SKUL BASE FX/HEM NEC	72
80181	OPN SKL BASE FX W/O COMA	72
80182	OPN SKL BASE FX-BRF COMA	72
80183	OPN SKL BASE FX-MOD COMA	72
80184	OP SKL BASE FX-PROL COMA	72
80185	OP SKL BASE FX-DEEP COMA	72
80186	OPN SKL BASE FX-COMA NOS	72
80189	OPN SKUL BASE FX-CONCUSS	72
80190	OP SK BASE FX/BR INJ NEC	72
80191	OP SKUL BASE FX W/O COMA	72
80192	OPN SKL BASE FX-BRF COMA	72
80193	OPN SKL BASE FX-MOD COMA	72
80194	OP SKL BASE FX-PROL COMA	72
80195	OP SKL BASE FX-DEEP COMA	72
80196	OPN SKL BASE FX-COMA NOS	72
80199	OPN SKUL BASE FX-CONCUSS	72
8020	NASAL BONE FX-CLOSED	72
8021	NASAL BONE FX-OPEN	72
80220	MANDIBLE FX NOS-CLOSED	72
80221	FX CONDYL PROC MANDIB-CL	72
80222	SUBCONDYLAR FX MANDIB-CL	72
80223	FX CORON PROC MANDIB-CL	72
80224	FX RAMUS NOS-CLOSED	72
80225	FX ANGLE OF JAW-CLOSED	72

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
80226	FX SYMPHY MANDIB BODY-CL	72
80227	FX ALVEOLAR BORD MAND-CL	72
80228	FX MANDIBLE BODY NEC-CL	72
80229	MULT FX MANDIBLE-CLOSED	72
80230	MANDIBLE FX NOS-OPEN	72
80231	FX CONDYL PROC MAND-OPEN	72
80232	SUBCONDYL FX MANDIB-OPEN	72
80233	FX CORON PROC MANDIB-OPN	72
80234	FX RAMUS NOS-OPEN	72
80235	FX ANGLE OF JAW-OPEN	72
80236	FX SYMPHY MANDIB BDY-OPN	72
80237	FX ALV BORD MAND BDY-OPN	72
80238	FX MANDIBLE BODY NEC-OPN	72
80239	MULT FX MANDIBLE-OPEN	72
8024	FX MALAR/MAXILLARY-CLOSE	72
8025	FX MALAR/MAXILLARY-OPEN	72
8026	FX ORBITAL FLOOR-CLOSED	72
8027	FX ORBITAL FLOOR-OPEN	72
8028	FX FACIAL BONE NEC-CLOSE	72
8029	FX FACIAL BONE NEC-OPEN	72
80300	CLOSE SKULL FRACTURE NEC	72
80301	CL SKULL FX NEC W/O COMA	72
80302	CL SKULL FX NEC-BRF COMA	72
80303	CL SKULL FX NEC-MOD COMA	72
80304	CL SKL FX NEC-PROLN COMA	72
80305	CL SKUL FX NEC-DEEP COMA	72
80306	CL SKULL FX NEC-COMA NOS	72
80309	CL SKULL FX NEC-CONCUSS	72
80310	CL SKL FX NEC/CEREBR LAC	72
80311	CL SKULL FX NEC W/O COMA	72
80312	CL SKULL FX NEC-BRF COMA	72
80313	CL SKULL FX NEC-MOD COMA	72
80314	CL SKL FX NEC-PROLN COMA	72
80315	CL SKUL FX NEC-DEEP COMA	72
80316	CL SKULL FX NEC-COMA NOS	72
80319	CL SKULL FX NEC-CONCUSS	72
80320	CL SKL FX NEC/MENING HEM	72
80321	CL SKULL FX NEC W/O COMA	72
80322	CL SKULL FX NEC-BRF COMA	72
80323	CL SKULL FX NEC-MOD COMA	72
80324	CL SKL FX NEC-PROLN COMA	72
80325	CL SKUL FX NEC-DEEP COMA	72
80326	CL SKULL FX NEC-COMA NOS	72
80329	CL SKULL FX NEC-CONCUSS	72
80330	CL SKULL FX NEC/HEM NEC	72
80331	CL SKULL FX NEC W/O COMA	72
80332	CL SKULL FX NEC-BRF COMA	72
80333	CL SKULL FX NEC-MOD COMA	72
80334	CL SKL FX NEC-PROLN COMA	72
80335	CL SKUL FX NEC-DEEP COMA	72
80336	CL SKULL FX NEC-COMA NOS	72
80339	CL SKULL FX NEC-CONCUSS	72
80340	CL SKL FX NEC/BR INJ NEC	72
80341	CL SKULL FX NEC W/O COMA	72
80342	CL SKULL FX NEC-BRF COMA	72
80343	CL SKULL FX NEC-MOD COMA	72
80344	CL SKL FX NEC-PROLN COMA	72
80345	CL SKUL FX NEC-DEEP COMA	72
80346	CL SKULL FX NEC-COMA NOS	72
80349	CL SKULL FX NEC-CONCUSS	72
80350	OPEN SKULL FRACTURE NEC	72
80351	OPN SKUL FX NEC W/O COMA	72
80352	OPN SKUL FX NEC-BRF COMA	72
80353	OPN SKUL FX NEC-MOD COMA	72
80354	OPN SKL FX NEC-PROL COMA	72
80355	OPN SKL FX NEC-DEEP COMA	72
80356	OPN SKUL FX NEC-COMA NOS	72
80359	OPN SKULL FX NEC-CONCUSS	72
80360	OPN SKL FX NEC/CEREB LAC	72
80361	OPN SKUL FX NEC W/O COMA	72
80362	OPN SKUL FX NEC-BRF COMA	72
80363	OPN SKUL FX NEC-MOD COMA	72
80364	OPN SKL FX NEC-PROLN COM	72
80365	OPN SKL FX NEC-DEEP COMA	72
80366	OPN SKUL FX NEC-COMA NOS	72
80369	OPN SKULL FX NEC-CONCUSS	72

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
80370	OPN SKL FX NEC/MENIN HEM	72
80371	OPN SKUL FX NEC W/O COMA	72
80372	OPN SKUL FX NEC-BRF COMA	72
80373	OPN SKUL FX NEC-MOD COMA	72
80374	OPN SKL FX NEC-PROL COMA	72
80375	OPN SKL FX NEC-DEEP COMA	72
80376	OPN SKUL FX NEC-COMA NOS	72
80379	OPN SKULL FX NEC-CONCUSS	72
80380	OPN SKULL FX NEC/HEM NEC	72
80381	OPN SKUL FX NEC W/O COMA	72
80382	OPN SKUL FX NEC-BRF COMA	72
80383	OPN SKUL FX NEC-MOD COMA	72
80384	OPN SKL FX NEC-PROL COMA	72
80385	OPN SKL FX NEC-DEEP COMA	72
80386	OPN SKUL FX NEC-COMA NOS	72
80389	OPN SKULL FX NEC-CONCUSS	72
80390	OP SKL FX NEC/BR INJ NEC	72
80391	OPN SKUL FX NEC W/O COMA	72
80392	OPN SKUL FX NEC-BRF COMA	72
80393	OPN SKUL FX NEC-MOD COMA	72
80394	OPN SKL FX NEC-PROL COMA	72
80395	OPN SKL FX NEC-DEEP COMA	72
80396	OPN SKUL FX NEC-COMA NOS	72
80399	OPN SKULL FX NEC-CONCUSS	72
80400	CL SKUL FX W OTH BONE FX	72
80401	CL SKL W OTH FX W/O COMA	72
80402	CL SKL W OTH FX-BRF COMA	72
80403	CL SKL W OTH FX-MOD COMA	72
80404	CL SKL/OTH FX-PROLN COMA	72
80405	CL SKUL/OTH FX-DEEP COMA	72
80406	CL SKL W OTH FX-COMA NOS	72
80409	CL SKUL W OTH FX-CONCUSS	72
80410	CL SK W OTH FX/CEREB LAC	72
80411	CL SKL W OTH FX W/O COMA	72
80412	CL SKL W OTH FX-BRF COMA	72
80413	CL SKL W OTH FX-MOD COMA	72
80414	CL SKL/OTH FX-PROLN COMA	72
80415	CL SKUL/OTH FX-DEEP COMA	72
80416	CL SKL W OTH FX-COMA NOS	72
80419	CL SKUL W OTH FX-CONCUSS	72
80420	CL SKL/OTH FX/MENING HEM	72
80421	CL SKL W OTH FX W/O COMA	72
80422	CL SKL W OTH FX-BRF COMA	72
80423	CL SKL W OTH FX-MOD COMA	72
80424	CL SKL/OTH FX-PROLN COMA	72
80425	CL SKUL/OTH FX-DEEP COMA	72
80426	CL SKL W OTH FX-COMA NOS	72
80429	CL SKUL W OTH FX-CONCUSS	72
80430	CL SKUL W OTH FX/HEM NEC	72
80431	CL SKL W OTH FX W/O COMA	72
80432	CL SKL W OTH FX-BRF COMA	72
80433	CL SKL W OTH FX-MOD COMA	72
80434	CL SKL/OTH FX-PROLN COMA	72
80435	CL SKUL/OTH FX-DEEP COMA	72
80436	CL SKL W OTH FX-COMA NOS	72
80439	CL SKUL W OTH FX-CONCUSS	72
80440	CL SKL/OTH FX/BR INJ NEC	72
80441	CL SKL W OTH FX W/O COMA	72
80442	CL SKL W OTH FX-BRF COMA	72
80443	CL SKL W OTH FX-MOD COMA	72
80444	CL SKL/OTH FX-PROLN COMA	72
80445	CL SKUL/OTH FX-DEEP COMA	72
80446	CL SKL W OTH FX-COMA NOS	72
80449	CL SKUL W OTH FX-CONCUSS	72
80450	OPN SKULL FX/OTH BONE FX	72
80451	OPN SKUL/OTH FX W/O COMA	72
80452	OPN SKUL/OTH FX-BRF COMA	72
80453	OPN SKUL/OTH FX-MOD COMA	72
80454	OPN SKL/OTH FX-PROL COMA	72
80455	OPN SKL/OTH FX-DEEP COMA	72
80456	OPN SKUL/OTH FX-COMA NOS	72
80459	OPN SKULL/OTH FX-CONCUSS	72
80460	OPN SKL/OTH FX/CEREB LAC	72
80461	OPN SKUL/OTH FX W/O COMA	72
80462	OPN SKUL/OTH FX-BRF COMA	72
80463	OPN SKUL/OTH FX-MOD COMA	72

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
80464	OPN SKL/OTH FX-PROL COMA	72
80465	OPN SKL/OTH FX-DEEP COMA	72
80466	OPN SKUL/OTH FX-COMA NOS	72
80469	OPN SKULL/OTH FX-CONCUSS	72
80470	OPN SKL/OTH FX/MENIN HEM	72
80471	OPN SKUL/OTH FX W/O COMA	72
80472	OPN SKUL/OTH FX-BRF COMA	72
80473	OPN SKUL/OTH FX-MOD COMA	72
80474	OPN SKL/OTH FX-PROL COMA	72
80475	OPN SKL/OTH FX-DEEP COMA	72
80476	OPN SKUL/OTH FX-COMA NOS	72
80479	OPN SKULL/OTH FX-CONCUSS	72
80480	OPN SKL W OTH FX/HEM NEC	72
80481	OPN SKUL/OTH FX W/O COMA	72
80482	OPN SKUL/OTH FX-BRF COMA	72
80483	OPN SKUL/OTH FX-MOD COMA	72
80484	OPN SKL/OTH FX-PROL COMA	72
80485	OPN SKL/OTH FX-DEEP COMA	72
80486	OPN SKUL/OTH FX-COMA NOS	72
80489	OPN SKULL/OTH FX-CONCUSS	72
80490	OP SKL/OTH FX/BR INJ NEC	72
80491	OPN SKUL/OTH FX W/O COMA	72
80492	OPN SKUL/OTH FX-BRF COMA	72
80493	OPN SKUL/OTH FX-MOD COMA	72
80494	OPN SKL/OTH FX-PROL COMA	72
80495	OPN SKL/OTH FX-DEEP COMA	72
80496	OPN SKUL/OTH FX-COMA NOS	72
80499	OPN SKULL/OTH FX-CONCUSS	72
80500	FX CERVICAL VERT NOS-CL	72
80501	FX C1 VERTEBRA-CLOSED	72
80502	FX C2 VERTEBRA-CLOSED	72
80503	FX C3 VERTEBRA-CLOSED	72
80504	FX C4 VERTEBRA-CLOSED	72
80505	FX C5 VERTEBRA-CLOSED	72
80506	FX C6 VERTEBRA-CLOSED	72
80507	FX C7 VERTEBRA-CLOSED	72
80508	FX MULT CERVICAL VERT-CL	72
80510	FX CERVICAL VERT NOS-OPN	72
80511	FX C1 VERTEBRA-OPEN	72
80512	FX C2 VERTEBRA-OPEN	72
80513	FX C3 VERTEBRA-OPEN	72
80514	FX C4 VERTEBRA-OPEN	72
80515	FX C5 VERTEBRA-OPEN	72
80516	FX C6 VERTEBRA-OPEN	72
80517	FX C7 VERTEBRA-OPEN	72
80518	FX MLT CERVICAL VERT-OPN	72
8052	FX DORSAL VERTEBRA-CLOSE	72
8053	FX DORSAL VERTEBRA-OPEN	72
8054	FX LUMBAR VERTEBRA-CLOSE	72
8055	FX LUMBAR VERTEBRA-OPEN	72
8056	FX SACRUM/COCCYX-CLOSED	24
8057	FX SACRUM/COCCYX-OPEN	24
8058	VERTEBRAL FX NOS-CLOSED	72
8059	VERTEBRAL FX NOS-OPEN	72
80600	C1-C4 FX-CL/CORD INJ NOS	72
80601	C1-C4 FX-CL/COM CORD LES	72
80602	C1-C4 FX-CL/ANT CORD SYN	72
80603	C1-C4 FX-CL/CEN CORD SYN	72
80604	C1-C4 FX-CL/CORD INJ NEC	72
80605	C5-C7 FX-CL/CORD INJ NOS	72
80606	C5-C7 FX-CL/COM CORD LES	72
80607	C5-C7 FX-CL/ANT CORD SYN	72
80608	C5-C7 FX-CL/CEN CORD SYN	72
80609	C5-C7 FX-CL/CORD INJ NEC	72
80610	C1-C4 FX-OP/CORD INJ NOS	72
80611	C1-C4 FX-OP/COM CORD LES	72
80612	C1-C4 FX-OP/ANT CORD SYN	72
80613	C1-C4 FX-OP/CEN CORD SYN	72
80614	C1-C4 FX-OP/CORD INJ NEC	72
0615	C5-C7 FX-OP/CORD INJ NOS	72
80616	C5-C7 FX-OP/COM CORD LES	72
80617	C5-C7 FX-OP/ANT CORD SYN	72
80618	C5-C7 FX-OP/CEN CORD SYN	72
80619	C5-C7 FX-OP/CORD INJ NEC	72
80620	T1-T6 FX-CL/CORD INJ NOS	72
80621	T1-T6 FX-CL/COM CORD LES	72

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
80622	T1-T6 FX-CL/ANT CORD SYN	72
80623	T1-T6 FX-CL/CEN CORD SYN	72
80624	T1-T6 FX-CL/CORD INJ NEC	72
80625	T7-T12 FX-CL/CRD INJ NOS	72
80626	T7-T12 FX-CL/COM CRD LES	72
80627	T7-T12 FX-CL/ANT CRD SYN	72
80628	T7-T12 FX-CL/CEN CRD SYN	72
80629	T7-T12 FX-CL/CRD INJ NEC	72
80630	T1-T6 FX-OP/CORD INJ NOS	72
80631	T1-T6 FX-OP/COM CORD LES	72
80632	T1-T6 FX-OP/ANT CORD SYN	72
80633	T1-T6 FX-OP/CEN CORD SYN	72
80634	T1-T6 FX-OP/CORD INJ NEC	72
80635	T7-T12 FX-OP/CRD INJ NOS	72
80636	T7-T12 FX-OP/COM CRD LES	72
80637	T7-T12 FX-OP/ANT CRD SYN	72
80638	T7-T12 FX-OP/CEN CRD SYN	72
80639	T7-T12 FX-OP/CRD INJ NEC	72
8064	CL LUMBAR FX W CORD INJ	72
8065	OPN LUMBAR FX W CORD INJ	72
80660	FX SACRUM-CL/CRD INJ NOS	72
80661	FX SACR-CL/CAUDA EQU LES	72
80662	FX SACR-CL/CAUDA INJ NEC	72
80669	FX SACRUM-CL/CRD INJ NEC	72
80670	FX SACRUM-OP/CRD INJ NOS	72
80671	FX SACR-OP/CAUDA EQU LES	72
80672	FX SACR-OP/CAUDA INJ NEC	72
80679	FX SACRUM-OP/CRD INJ NEC	72
8068	VERT FX NOS-CL W CRD INJ	72
8069	VERT FX NOS-OP W CRD INJ	72
80700	FRACTURE RIB NOS-CLOSED	72
80701	FRACTURE ONE RIB-CLOSED	72
80702	FRACTURE TWO RIBS-CLOSED	72
80703	FRACTURE THREE RIBS-CLOS	72
80704	FRACTURE FOUR RIBS-CLOSE	72
80705	FRACTURE FIVE RIBS-CLOSE	72
80706	FRACTURE SIX RIBS-CLOSED	72
80707	FRACTURE SEVEN RIBS-CLOS	72
80708	FX EIGHT/MORE RIB-CLOSED	72
80709	FX MULT RIBS NOS-CLOSED	72
80710	FRACTURE RIB NOS-OPEN	72
80711	FRACTURE ONE RIB-OPEN	72
80712	FRACTURE TWO RIBS-OPEN	72
80713	FRACTURE THREE RIBS-OPEN	72
80714	FRACTURE FOUR RIBS-OPEN	72
80715	FRACTURE FIVE RIBS-OPEN	72
80716	FRACTURE SIX RIBS-OPEN	72
80717	FRACTURE SEVEN RIBS-OPEN	72
80718	FX EIGHT/MORE RIBS-OPEN	72
80719	FX MULT RIBS NOS-OPEN	72
8072	FRACTURE OF STERNUM-CLOS	72
8073	FRACTURE OF STERNUM-OPEN	72
8074	FLAIL CHEST	72
8075	FX LARYNX/TRACHEA-CLOSED	72
8076	FX LARYNX/TRACHEA-OPEN	72
8080	FRACTURE ACETABULUM-CLOS	72
8081	FRACTURE ACETABULUM-OPEN	72
8082	FRACTURE OF PUBIS-CLOSED	72
8083	FRACTURE OF PUBIS-OPEN	72
80841	FRACTURE OF ILIUM-CLOSED	72
80842	FRACTURE ISCHIUM-CLOSED	72
80843	PELV FX-CLOS/PELV DISRUP	72
80849	PELVIC FRACTURE NEC-CLOS	72
80851	FRACTURE OF ILIUM-OPEN	72
80852	FRACTURE OF ISCHIUM-OPEN	72
80853	PELV FX-OPEN/PELV DISRUP	72
80859	PELVIC FRACTURE NEC-OPEN	72
8088	PELVIC FRACTURE NOS-CLOS	72
8089	PELVIC FRACTURE NOS-OPEN	72
8090	FRACTURE TRUNK BONE-CLOS	72
8091	FRACTURE TRUNK BONE-OPEN	72
81000	FX CLAVICLE NOS-CLOSED	72
81001	FX CLAVICL, STERN END-CL	72
81002	FX CLAVICLE SHAFT-CLOSED	72
81003	FX CLAVICL, ACROM END-CL	72
81010	FX CLAVICLE NOS-OPEN	72

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
81011	FX CLAVIC, STERN END-OPN	72
81012	FX CLAVICLE SHAFT-OPEN	72
81013	FX CLAVIC, ACROM END-OPN	72
81100	FX SCAPULA NOS-CLOSED	72
81101	FX SCAPUL, ACROM PROC-CL	72
81102	FX SCAPUL, CORAC PROC-CL	72
81103	FX SCAP, GLEN CAV/NCK-CL	72
81109	FX SCAPULA NEC-CLOSED	72
81110	FX SCAPULA NOS-OPEN	72
81111	FX SCAPUL, ACROM PROC-OP	72
81112	FX SCAPUL, CORAC PROC-OP	72
81113	FX SCAP, GLEN CAV/NCK-OP	72
81119	FX SCAPULA NEC-OPEN	72
81200	FX UP END HUMERUS NOS-CL	72
81201	FX SURG NCK HUMERUS-CLOS	72
81202	FX ANATOM NCK HUMERUS-CL	72
81203	FX GR TUBEROS HUMERUS-CL	72
81209	FX UPPER HUMERUS NEC-CL	72
81210	FX UPPER HUMERUS NOS-OPN	72
81211	FX SURG NECK HUMERUS-OPN	72
81212	FX ANAT NECK HUMERUS-OPN	72
81213	FX GR TUBEROS HUMER-OPEN	72
81219	FX UPPER HUMERUS NEC-OPN	72
81220	FX HUMERUS NOS-CLOSED	72
81221	FX HUMERUS SHAFT-CLOSED	72
81230	FX HUMERUS NOS-OPEN	72
81231	FX HUMERUS SHAFT-OPEN	72
81240	FX LOWER HUMERUS NOS-CL	72
81241	SUPRCONDYL FX HUMERUS-CL	72
81242	FX HUMER, LAT CONDYL-CL	72
81243	FX HUMER, MED CONDYL-CL	72
81244	FX HUMER, CONDYL NOS-CL	72
81249	FX LOWER HUMERUS NEC-CL	72
81250	FX LOWER HUMER NOS-OPEN	72
81251	SUPRACONDYL FX HUMER-OPN	72
81252	FX HUMER, LAT CONDYL-OPN	72
81253	FX HUMER, MED CONDYL-OPN	72
81254	FX HUMER, CONDYL NOS-OPN	72
81259	FX LOWER HUMER NEC-OPEN	72
81300	FX UPPER FOREARM NOS-CL	72
81301	FX OLECRAN PROC ULNA-CL	72
81302	FX CORONOID PROC ULNA-CL	72
81303	MONTEGGIA'S FX-CLOSED	72
81304	FX UPPER ULNA NEC/NOS-CL	72
81305	FX RADIUS HEAD-CLOSED	72
81306	FX RADIUS NECK-CLOSED	72
81307	FX UP RADIUS NEC/NOS-CL	72
81308	FX UP RADIUS W ULNA-CLOS	72
81310	FX UPPER FOREARM NOS-OPN	72
81311	FX OLECRAN PROC ULNA-OPN	72
81312	FX CORONOID PRO ULNA-OPN	72
81313	MONTEGGIA'S FX-OPEN	72
81314	FX UP ULNA NEC/NOS-OPEN	72
81315	FX RADIUS HEAD-OPEN	72
81316	FX RADIUS NECK-OPEN	72
81317	FX UP RADIUS NEC/NOS-OPN	72
81318	FX UP RADIUS W ULNA-OPEN	72
81320	FX SHAFT FOREARM NOS-CL	72
81321	FX RADIUS SHAFT-CLOSED	72
81322	FX ULNA SHAFT-CLOSED	72
81323	FX SHAFT RAD W ULNA-CLOS	72
81330	FX SHAFT FOREARM NOS-OPN	72
81331	FX RADIUS SHAFT-OPEN	72
81332	FX ULNA SHAFT-OPEN	72
81333	FX SHAFT RAD W ULNA-OPEN	72
81340	FX LOWER FOREARM NOS-CL	72
81341	COLLES' FRACTURE-CLOSED	72
81342	FX DISTAL RADIUS NEC-CL	72
81343	FX DISTAL ULNA-CLOSED	72
81344	FX LOW RADIUS W ULNA-CL	72
81350	FX LOWER FOREARM NOS-OPN	72
81351	COLLES' FRACTURE-OPEN	72
81352	FX DISTAL RADIUS NEC-OPN	72
81353	FX DISTAL ULNA-OPEN	72
81354	FX LOW RADIUS W ULNA-OPN	72
81380	FX FOREARM NOS-CLOSED	72

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
81381	FX RADIUS NOS-CLOSED	72
81382	FRACTURE ULNA NOS-CLOSED	72
81383	FX RADIUS W ULNA NOS-CL	72
81390	FX FOREARM NOS-OPEN	72
81391	FRACTURE RADIUS NOS-OPEN	72
81392	FRACTURE ULNA NOS-OPEN	72
81393	FX RADIUS W ULNA NOS-OPN	72
81400	FX CARPAL BONE NOS-CLOSE	72
81401	FX NAVICULAR, WRIST-CLOS	72
81402	FX LUNATE, WRIST-CLOSED	72
81403	FX TRIQUETRAL, WRIST-CL	72
81404	FX PISIFORM-CLOSED	72
81405	FX TRAPEZIUM BONE-CLOSED	72
81406	FX TRAPEZOID BONE-CLOSED	72
81407	FX CAPITATE BONE-CLOSED	72
81408	FX HAMATE BONE-CLOSED	72
81409	FX CARPAL BONE NEC-CLOSE	72
81410	FX CARPAL BONE NOS-OPEN	72
81411	FX NAVICULAR, WRIST-OPEN	72
81412	FX LUNATE, WRIST-OPEN	72
81413	FX TRIQUETRAL, WRIST-OPN	72
81414	FX PISIFORM-OPEN	72
81415	FX TRAPEZIUM BONE-OPEN	72
81416	FX TRAPEZOID BONE-OPEN	72
81417	FX CAPITATE BONE-OPEN	72
81418	FX HAMATE BONE-OPEN	72
81419	FX CARPAL BONE NEC-OPEN	72
81500	FX METACARPAL NOS-CLOSED	72
81501	FX 1ST METACARP BASE-CL	72
81502	FX METACARP BASE NEC-CL	72
81503	FX METACARPAL SHAFT-CLOS	72
81504	FX METACARPAL NECK-CLOSE	72
81509	MULT FX METACARPUS-CLOSE	72
81510	FX METACARPAL NOS-OPEN	72
81511	FX 1ST METACARP BASE-OPN	72
81512	FX METACARP BASE NEC-OPN	72
81513	FX METACARPAL SHAFT-OPEN	72
81514	FX METACARPAL NECK-OPEN	72
81519	MULT FX METACARPUS-OPEN	72
81600	FX PHALANX, HAND NOS-CL	72
81601	FX MID/PRX PHAL, HAND-CL	72
81602	FX DIST PHALANX, HAND-CL	72
81603	FX MULT PHALAN, HAND-CL	72
81610	FX PHALANX, HAND NOS-OPN	72
81611	FX MID/PRX PHAL, HAND-OP	72
81612	FX DISTAL PHAL, HAND-OPN	72
81613	FX MULT PHALAN, HAND-OPN	72
8170	MULTIPLE FX HAND-CLOSED	72
8171	MULTIPLE FX HAND-OPEN	72
8180	FX ARM MULT/NOS-CLOSED	72
8181	FX ARM MULT/NOS-OPEN	72
8190	FX ARMS W RIB/STERNUM-CL	72
8191	FX ARMS W RIB/STERN-OPEN	72
82000	FX FEMUR INTRCAPS NOS-CL	72
82001	FX UP FEMUR EPIPHY-CLOS	72
82002	FX FEMUR, MIDCERVIC-CLOS	72
82003	FX BASE FEMORAL NCK-CLOS	72
82009	FX FEMUR INTRCAPS NEC-CL	72
82010	FX FEMUR INTRCAP NOS-OPN	72
82011	FX UP FEMUR EPIPHY-OPEN	72
82012	FX FEMUR, MIDCERVIC-OPEN	72
82013	FX BASE FEMORAL NCK-OPEN	72
82019	FX FEMUR INTRCAP NEC-OPN	72
82020	TROCHANTERIC FX NOS-CLOS	72
82021	INTERTROCHANTERIC FX-CL	72
82022	SUBTROCHANTERIC FX-CLOSE	72
82030	TROCHANTERIC FX NOS-OPEN	72
82031	INTERTROCHANTERIC FX-OPN	72
82032	SUBTROCHANTERIC FX-OPEN	72
8208	FX NECK OF FEMUR NOS-CL	72
8209	FX NECK OF FEMUR NOS-OPN	72
82100	FX FEMUR NOS-CLOSED	72
82101	FX FEMUR SHAFT-CLOSED	72
82110	FX FEMUR NOS-OPEN	72
82111	FX FEMUR SHAFT-OPEN	72
82120	FX LOW END FEMUR NOS-CL	72

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
82121	FX FEMORAL CONDYLE-CLOSE	72
82122	FX LOW FEMUR EPIPHY-CLOS	72
82123	SUPRACONDYL FX FEMUR-CL	72
82129	FX LOW END FEMUR NEC-CL	72
82130	FX LOW END FEMUR NOS-OPN	72
82131	FX FEMORAL CONDYLE-OPEN	72
82132	FX LOW FEMUR EPIPHY-OPEN	72
82133	SUPRACONDYL FX FEMUR-OPN	72
82139	FX LOW END FEMUR NEC-OPN	72
8220	FRACTURE PATELLA-CLOSED	72
8221	FRACTURE PATELLA-OPEN	72
82300	FX UPPER END TIBIA-CLOSE	72
82301	FX UPPER END FIBULA-CLOS	72
82302	FX UP TIBIA W FIBULA-CL	72
82310	FX UPPER END TIBIA-OPEN	72
82311	FX UPPER END FIBULA-OPEN	72
82312	FX UP TIBIA W FIBULA-OPN	72
82320	FX SHAFT TIBIA-CLOSED	72
82321	FX SHAFT FIBULA-CLOSED	72
82322	FX SHAFT FIB W TIB-CLOS	72
82330	FX TIBIA SHAFT-OPEN	72
82331	FX FIBULA SHAFT-OPEN	72
82332	FX SHAFT TIBIA W FIB-OPN	72
82380	FX TIBIA NOS-CLOSED	72
82381	FX FIBULA NOS-CLOSED	72
82382	FX TIBIA W FIBULA NOS-CL	72
82390	FX TIBIA NOS-OPEN	72
82391	FX FIBULA NOS-OPEN	72
82392	FX TIBIA W FIB NOS-OPEN	72
8240	FX MEDIAL MALLEOLUS-CLOS	72
8241	FX MEDIAL MALLEOLUS-OPEN	72
8242	FX LATERAL MALLEOLUS-CL	72
8243	FX LATERAL MALLEOLUS-OPN	72
8244	FX BIMALLEOLAR-CLOSED	72
8245	FX BIMALLEOLAR-OPEN	72
8246	FX TRIMALLEOLAR-CLOSED	72
8247	FX TRIMALLEOLAR-OPEN	72
8248	FX ANKLE NOS-CLOSED	72
8249	FX ANKLE NOS-OPEN	72
8250	FRACTURE CALCANEUS-CLOSE	72
8251	FRACTURE CALCANEUS-OPEN	72
82520	FX FOOT BONE NOS-CLOSED	72
82521	FX ASTRAGALUS-CLOSED	72
82522	FX NAVICULAR, FOOT-CLOS	72
82523	FX CUBOID-CLOSED	72
82524	FX CUNEIFORM, FOOT-CLOS	72
82525	FX METATARSAL-CLOSED	72
82529	FX FOOT BONE NEC-CLOSED	72
82530	FX FOOT BONE NOS-OPEN	72
82531	FX ASTRAGALUS-OPEN	72
82532	FX NAVICULAR, FOOT-OPEN	72
82533	FX CUBOID-OPEN	72
82534	FX CUNEIFORM, FOOT-OPEN	72
82535	FX METATARSAL-OPEN	72
82539	FX FOOT BONE NEC-OPEN	72
8260	FX PHALANX, FOOT-CLOSED	72
8261	FX PHALANX, FOOT-OPEN	72
8270	FX LOWER LIMB NEC-CLOSED	72
8271	FX LOWER LIMB NEC-OPEN	72
8280	FX LEGS W ARM/RIB-CLOSED	72
8281	FX LEGS W ARM/RIB-OPEN	72
8290	FRACTURE NOS-CLOSED	72
8291	FRACTURE NOS-OPEN	72
8300	DISLOCATION JAW-CLOSED	72
8301	DISLOCATION JAW-OPEN	72
83100	DISLOC SHOULDER NOS-CLOS	72
83101	ANT DISLOC HUMERUS-CLOSE	72
83102	POST DISLOC HUMERUS-CLOS	72
83103	INFER DISLOC HUMERUS-CL	72
83104	DISLOC ACROMIOCLAVIC-CL	72
83109	DISLOC SHOULDER NEC-CLOS	72
83110	DISLOC SHOULDER NOS-OPEN	72
83111	ANT DISLOC HUMERUS-OPEN	72
83112	POST DISLOC HUMERUS-OPEN	72
83113	INFER DISLOC HUMERUS-OPN	72
83114	DISLOC ACROMIOCLAVIC-OPN	72

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
83119	DISLOC SHOULDER NEC-OPEN	72
83200	DISLOCAT ELBOW NOS-CLOSE	72
83201	ANT DISLOC ELBOW-CLOSED	72
83202	POST DISLOC ELBOW-CLOSED	72
83203	MED DISLOC ELBOW-CLOSED	72
83204	LAT DISLOC ELBOW-CLOSED	72
83209	DISLOCAT ELBOW NEC-CLOSE	72
83210	DISLOCAT ELBOW NOS-OPEN	72
83211	ANT DISLOC ELBOW-OPEN	72
83212	POST DISLOC ELBOW-OPEN	72
83213	MED DISLOC ELBOW-OPEN	72
83214	LAT DISLOCAT ELBOW-OPEN	72
83219	DISLOCAT ELBOW NEC-OPEN	72
83300	DISLOC WRIST NOS-CLOSED	72
83301	DISLOC DIST RADIOULN-CL	72
83302	DISLOC RADIOCARPAL-CLOS	72
83303	DISLOCA MIDCARPAL-CLOSED	72
83304	DISLOC CARPOMETACARP-CL	72
83305	DISLOC METACARPAL-CLOSED	72
83309	DISLOC WRIST NEC-CLOSED	72
83310	DISLOCAT WRIST NOS-OPEN	72
83311	DISLOC DIST RADIOULN-OPN	72
83312	DISLOC RADIOCARPAL-OPEN	72
83313	DISLOCAT MIDCARPAL-OPEN	72
83314	DISLOC CARPOMETACARP-OPN	72
83315	DISLOCAT METACARPAL-OPEN	72
83319	DISLOCAT WRIST NEC-OPEN	72
83400	DISL FINGER NOS-CLOSED	72
83401	DISLOC METACARPOPHALN-CL	72
83402	DISL INTERPHALN HAND-CL	72
83410	DISLOC FINGER NOS-OPEN	72
83411	DISL METACARPOPHALAN-OPN	72
83412	DISL INTERPHALN HAND-OPN	72
83500	DISLOCAT HIP NOS-CLOSED	72
83501	POSTERIOR DISLOC HIP-CL	72
83502	OBTURATOR DISLOC HIP-CL	72
83503	ANT DISLOC HIP NEC-CLOS	72
83510	DISLOCATION HIP NOS-OPEN	72
83511	POSTERIOR DISLOC HIP-OPN	72
83512	OBTURATOR DISLOC HIP-OPN	72
83513	ANT DISLOC HIP NEC-OPEN	72
8360	TEAR MED MENISC KNEE-CUR	72
8361	TEAR LAT MENISC KNEE-CUR	72
8362	TEAR MENISCUS NEC-CURREN	72
8363	DISLOCAT PATELLA-CLOSED	72
8364	DISLOCATION PATELLA-OPEN	72
83650	DISLOCAT KNEE NOS-CLOSED	72
83651	ANT DISLOC PROX TIBIA-CL	72
83652	POST DISL PROX TIBIA-CL	72
83653	MED DISLOC PROX TIBIA-CL	72
83654	LAT DISLOC PROX TIBIA-CL	72
83659	DISLOCAT KNEE NEC-CLOSED	72
83660	DISLOCAT KNEE NOS-OPEN	72
83661	ANT DISL PROX TIBIA-OPEN	72
83662	POST DISL PROX TIBIA-OPN	72
83663	MED DISL PROX TIBIA-OPEN	72
83664	LAT DISL PROX TIBIA-OPEN	72
83669	DISLOCAT KNEE NEC-OPEN	72
8370	DISLOCATION ANKLE-CLOSED	72
8371	DISLOCATION ANKLE-OPEN	72
83800	DISLOCAT FOOT NOS-CLOSED	72
83801	DISLOC TARSAL NOS-CLOSED	72
83802	DISLOC MIDTARSAL-CLOSED	72
83803	DISLOC TARSOMETATARS-CL	72
83804	DISLOC METATARSAL NOS-CL	72
83805	DISL METATARSOPHALANG-CL	72
83806	DISL INTERPHALAN FOOT-CL	72
83809	DISLOCAT FOOT NEC-CLOSED	72
83810	DISLOCAT FOOT NOS-OPEN	72
83811	DISLOC TARSAL NOS-OPEN	72
83812	DISLOC MIDTARSAL-OPEN	72
83813	DISL TARSOMETATARSAL-OPN	72
83814	DISL METATARSAL NOS-OPEN	72
83815	DISLOC METATARSOPHAL-OPN	72
83816	DIS INTERPHALAN FOOT-OPN	72
83819	DISLOCAT FOOT NEC-OPEN	72

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
83900	DISLOC CERV VERT NOS-CL	72
83901	DISLOC 1ST CERV VERT-CL	72
83902	DISLOC 2ND CERV VERT-CL	72
83903	DISLOC 3RD CERV VERT-CL	72
83904	DISLOC 4TH CERV VERT-CL	72
83905	DISLOC 5TH CERV VERT-CL	72
83906	DISLOC 6TH CERV VERT-CL	72
83907	DISLOC 7TH CERV VERT-CL	72
83908	DISLOC MULT CERV VERT-CL	72
83910	DISLOC CERV VERT NOS-OPN	72
83911	DISLOC LST CERV VERT-OPN	72
83912	DISLOC 2ND CERV VERT-OPN	72
83913	DISLOC 3RD CERV VERT-OPN	72
83914	DISLOC 4TH CERV VERT-OPN	72
83915	DISLOC 5TH CERV VERT-OPN	72
83916	DISLOC 6TH CERV VERT-OPN	72
83917	DISLOC 7TH CERV VERT-OPN	72
83918	DISLOC MLT CERV VERT-OPN	72
83920	DISLOCAT LUMBAR VERT-CL	72
83921	DISLOC THORACIC VERT-CL	72
83930	DISLOCAT LUMBAR VERT-OPN	72
83931	DISLOC THORACIC VERT-OPN	72
83940	DISLOCAT VERTEBRA NOS-CL	72
83941	DISLOCAT COCCYX-CLOSED	72
83942	DISLOCAT SACRUM-CLOSED	72
83949	DISLOCAT VERTEBRA NEC-CL	72
83950	DISLOC VERTEBRA NOS-OPEN	72
83951	DISLOCAT COCCYX-OPEN	72
83952	DISLOCAT SACRUM-OPEN	72
83959	DISLOC VERTEBRA NEC-OPEN	72
83961	DISLOCAT STERNUM-CLOSED	72
83969	DISLOCAT SITE NEC-CLOSED	72
83971	DISLOCATION STERNUM-OPEN	72
83979	DISLOCAT SITE NEC-OPEN	72
8398	DISLOCATION NEC-CLOSED	72
8399	DISLOCATION NEC-OPEN	72
8400	SPRAIN ACROMIOCLAVICULAR	72
8401	SPRAIN CORACOCLAVICULAR	72
8402	SPRAIN CORACOHUMERAL	72
8403	SPRAIN INFRASPINATUS	72
8404	SPRAIN ROTATOR CUFF	72
8405	SPRAIN SUBSCAPULARIS	72
8406	SPRAIN SUPRASPINATUS	72
8408	SPRAIN SHOULDER/ARM NEC	72
8409	SPRAIN SHOULDER/ARM NOS	72
8410	SPRAIN RADIAL COLLAT LIG	72
8411	SPRAIN ULNAR COLLAT LIG	72
8412	SPRAIN RADIOHUMERAL	72
8413	SPRAIN ULNOHUMERAL	72
8418	SPRAIN ELBOW/FOREARM NEC	72
8419	SPRAIN ELBOW/FOREARM NOS	72
84200	SPRAIN OF WRIST NOS	72
84201	SPRAIN CARPAL	72
84202	SPRAIN RADIOCARPAL	72
84209	SPRAIN OF WRIST NEC	72
84210	SPRAIN OF HAND NOS	72
84211	SPRAIN CARPOMETACARPAL	72
84212	SPRAIN METACARPOPHALANG	72
84213	SPRAIN INTERPHALANGEAL	72
84219	SPRAIN OF HAND NEC	72
8430	SPRAIN ILIOFEMORAL	72
8431	SPRAIN ISCHIOCAPSULAR	72
8438	SPRAIN HIP & THIGH NEC	72
8439	SPRAIN HIP & THIGH NOS	72
8440	SPRAIN LATERAL COLL LIG	72
8441	SPRAIN MEDIAL COLLAT LIG	72
8442	SPRAIN CRUCIATE LIG KNEE	72
8443	SPRAIN SUPER TIBIOFIBULA	72
8448	SPRAIN OF KNEE & LEG NEC	72
8449	SPRAIN OF KNEE & LEG NOS	72
84500	SPRAIN OF ANKLE NOS	72
84501	SPRAIN OF ANKLE DELTOID	72
84502	SPRAIN CALCANEOFIBULAR	72
84503	SPRAIN DISTAL TIBIOFIBUL	72
84509	SPRAIN OF ANKLE NEC	72
84510	SPRAIN OF FOOT NOS	72

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
84511	SPRAIN TARSOMETATARSAL	72
84512	SPRAIN METATARSOPHALANG	72
84513	SPRAIN INTERPHALANG TOE	72
84519	SPRAIN OF FOOT NEC	72
8460	SPRAIN LUMBOSACRAL	72
8461	SPRAIN SACROILIAC	72
8462	SPRAIN SACROSPINATUS	72
8463	SPRAIN SACROTUBEROUS	72
8468	SPRAIN SACROILIAC NEC	72
8469	SPRAIN SACROILIAC NOS	72
8470	SPRAIN OF NECK	72
8471	SPRAIN THORACIC REGION	72
8472	SPRAIN LUMBAR REGION	72
8473	SPRAIN OF SACRUM	72
8474	SPRAIN OF COCCYX	72
8479	SPRAIN OF BACK NOS	72
8480	SPRAIN OF NASAL SEPTUM	72
8481	SPRAIN OF JAW	72
8482	SPRAIN OF THYROID REGION	72
8483	SPRAIN OF RIBS	72
84840	SPRAIN OF STERNUM NOS	72
84841	SPRAIN STERNOCLAVICULAR	72
84842	SPRAIN CHONDROSTERNAL	72
84849	SPRAIN OF STERNUM NEC	72
8485	SPRAIN OF PELVIS	72
8488	SPRAIN NEC	72
8489	SPRAIN NOS	72
8500	CONCUSSION W/O COMA	72
8501	CONCUSSION-BRIEF COMA	72
8502	CONCUSSION-MODERATE COMA	72
8503	CONCUSSION-PROLONG COMA	72
8504	CONCUSSION-DEEP COMA	72
8505	CONCUSSION W COMA NOS	72
8509	CONCUSSION NOS	72
85100	CEREBRAL CORTX CONTUSION	72
85101	CORTEX CONTUSION-NO COMA	72
85102	CORTEX CONTUS-BRIEF COMA	72
85103	CORTEX CONTUS-MOD COMA	72
85104	CORTX CONTUS-PROLNG COMA	72
85105	CORTEX CONTUS-DEEP COMA	72
85106	CORTEX CONTUS-COMA NOS	72
85109	CORTEX CONTUS-CONCUS NOS	72
85110	CORTEX CONTUSION/OPN WND	72
85111	OPN CORTX CONTUS-NO COMA	72
85112	OPN CORT CONTUS-BRF COMA	72
85113	OPN CORT CONTUS-MOD COMA	72
85114	OPN CORT CONTU-PROL COMA	72
85115	OPN CORT CONTU-DEEP COMA	72
85116	OPN CORT CONTUS-COMA NOS	72
85119	OPN CORTX CONTUS-CONCUSS	72
85120	CEREBRAL CORTEX LACERAT	72
85121	CORTEX LACERAT W/O COMA	72
85122	CORTEX LACERA-BRIEF COMA	72
85123	CORTEX LACERAT-MOD COMA	72
85124	CORTEX LACERAT-PROL COMA	72
85125	CORTEX LACERAT-DEEP COMA	72
85126	CORTEX LACERAT-COMA NOS	72
85129	CORTEX LACERAT-CONCUSS	72
85130	CORTEX LACER W OPN WOUND	72
85131	OPN CORTEX LACER-NO COMA	72
85132	OPN CORTX LAC-BRIEF COMA	72
85133	OPN CORTX LACER-MOD COMA	72
85134	OPN CORTX LAC-PROLN COMA	72
85135	OPN CORTEX LAC-DEEP COMA	72
85136	OPN CORTX LACER-COMA NOS	72
85139	OPN CORTX LACER-CONCUSS	72
85140	CEREBEL/BRAIN STM CONTUS	72
85141	CEREBELL CONTUS W/O COMA	72
85142	CEREBELL CONTUS-BRF COMA	72
85143	CEREBELL CONTUS-MOD COMA	72
85144	CEREBEL CONTUS-PROL COMA	72
85145	CEREBEL CONTUS-DEEP COMA	72
85146	CEREBELL CONTUS-COMA NOS	72
85149	CEREBELL CONTUS-CONCUSS	72
85150	CEREBEL CONTUS W OPN WND	72
85151	OPN CEREBE CONT W/O COMA	72

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
85152	OPN CEREBE CONT-BRF COMA	72
85153	OPN CEREBE CONT-MOD COMA	72
85154	OPN CEREBE CONT-PROL COM	72
85155	OPN CEREBE CONT-DEEP COM	72
85156	OPN CEREBE CONT-COMA NOS	72
85159	OPN CEREBEL CONT-CONCUSS	72
85160	CEREBEL/BRAIN STEM LACER	72
85161	CEREBEL LACERAT W/O COMA	72
85162	CEREBEL LACER-BRIEF COMA	72
85163	CEREBEL LACERAT-MOD COMA	72
85164	CEREBEL LACER-PROLN COMA	72
85165	CEREBELL LACER-DEEP COMA	72
85166	CEREBEL LACERAT-COMA NOS	72
85169	CEREBEL LACER-CONCUSSION	72
85170	CEREBEL LACER W OPEN WND	72
85171	OPN CEREBEL LAC W/O COMA	72
85172	OPN CEREBEL LAC-BRF COMA	72
85173	OPN CEREBEL LAC-MOD COMA	72
85174	OPN CEREBE LAC-PROL COMA	72
85175	OPN CEREBE LAC-DEEP COMA	72
85176	OPN CEREBEL LAC-COMA NOS	72
85179	OPN CEREBELL LAC-CONCUSS	72
85180	BRAIN LACERATION NEC	72
85181	BRAIN LACER NEC W/O COMA	72
85182	BRAIN LAC NEC-BRIEF COMA	72
85183	BRAIN LACER NEC-MOD COMA	72
85184	BRAIN LAC NEC-PROLN COMA	72
85185	BRAIN LAC NEC-DEEP COMA	72
85186	BRAIN LACER NEC-COMA NOS	72
85189	BRAIN LACER NEC-CONCUSS	72
85190	BRAIN LAC NEC W OPEN WND	72
85191	OPN BRAIN LACER W/O COMA	72
85192	OPN BRAIN LAC-BRIEF COMA	72
85193	OPN BRAIN LACER-MOD COMA	72
85194	OPN BRAIN LAC-PROLN COMA	72
85195	OPEN BRAIN LAC-DEEP COMA	72
85196	OPN BRAIN LACER-COMA NOS	72
85199	OPEN BRAIN LACER-CONCUSS	72
85200	TRAUM SUBARACHNOID HEM	72
85201	SUBARACHNOID HEM-NO COMA	72
85202	SUBARACH HEM-BRIEF COMA	72
85203	SUBARACH HEM-MOD COMA	72
85204	SUBARACH HEM-PROLNG COMA	72
85205	SUBARACH HEM-DEEP COMA	72
85206	SUBARACH HEM-COMA NOS	72
85209	SUBARACH HEM-CONCUSSION	72
85210	SUBARACH HEM W OPN WOUND	72
85211	OPN SUBARACH HEM-NO COMA	72
85212	OP SUBARACH HEM-BRF COMA	72
85213	OP SUBARACH HEM-MOD COMA	72
85214	OP SUBARACH HEM-PROL COM	72
85215	OP SUBARACH HEM-DEEP COM	72
85216	OP SUBARACH HEM-COMA NOS	72
85219	OPN SUBARACH HEM-CONCUSS	72
85220	TRAUMATIC SUBDURAL HEM	72
85221	SUBDURAL HEM W/O COMA	72
85222	SUBDURAL HEM-BRIEF COMA	72
85223	SUBDURAL HEMORR-MOD COMA	72
85224	SUBDURAL HEM-PROLNG COMA	72
85225	SUBDURAL HEM-DEEP COMA	72
85226	SUBDURAL HEMORR-COMA NOS	72
85229	SUBDURAL HEM-CONCUSSION	72
85230	SUBDURAL HEM W OPN WOUND	72
85231	OPEN SUBDUR HEM W/O COMA	72
85232	OPN SUBDUR HEM-BRF COMA	72
85233	OPN SUBDUR HEM-MOD COMA	72
85234	OPN SUBDUR HEM-PROL COMA	72
85235	OPN SUBDUR HEM-DEEP COMA	72
85236	OPN SUBDUR HEM-COMA NOS	72
85239	OPN SUBDUR HEM-CONCUSS	72
85240	TRAUMATIC EXTRADURAL HEM	72
85241	EXTRADURAL HEM W/O COMA	72
85242	EXTRADUR HEM-BRIEF COMA	72
85243	EXTRADURAL HEM-MOD COMA	72
85244	EXTRADUR HEM-PROLN COMA	72
85245	EXTRADURAL HEM-DEEP COMA	72

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
85246	EXTRADURAL HEM-COMA NOS	72
85249	EXTADURAL HEM-CONCUSS	72
85250	EXTRADURAL HEM W OPN WND	72
85251	EXTRADURAL HEMOR-NO COMA	72
85252	EXTRADUR HEM-BRIEF COMA	72
85253	EXTRADURAL HEM-MOD COMA	72
85254	EXTRADUR HEM-PROLN COMA	72
85255	EXTRADUR HEM-DEEP COMA	72
85256	EXTRADURAL HEM-COMA NOS	72
85259	EXTRADURAL HEM-CONCUSS	72
85300	TRAUMATIC BRAIN HEM NEC	72
85301	BRAIN HEM NEC W/O COMA	72
85302	BRAIN HEM NEC-BRIEF COMA	72
85303	BRAIN HEM NEC-MOD COMA	72
85304	BRAIN HEM NEC-PROLN COMA	72
85305	BRAIN HEM NEC-DEEP COMA	72
85306	BRAIN HEM NEC-COMA NOS	72
85309	BRAIN HEM NEC-CONCUSSION	72
85310	BRAIN HEM NEC W OPN WND	72
85311	BRAIN HEM OPN W/O COMA	72
85312	BRAIN HEM OPN-BRF COMA	72
85313	BRAIN HEM OPEN-MOD COMA	72
85314	BRAIN HEM OPN-PROLN COMA	72
85315	BRAIN HEM OPEN-DEEP COMA	72
85316	BRAIN HEM OPEN-COMA NOS	72
85319	BRAIN HEM OPN-CONCUSSION	72
85400	BRAIN INJURY NEC	72
85401	BRAIN INJURY NEC-NO COMA	72
85402	BRAIN INJ NEC-BRIEF COMA	72
85403	BRAIN INJ NEC-MOD COMA	72
85404	BRAIN INJ NEC-PROLN COMA	72
85405	BRAIN INJ NEC-DEEP COMA	72
85406	BRAIN INJ NEC-COMA NOS	72
85409	BRAIN INJ NEC-CONCUSSION	72
85410	BRAIN INJURY W OPN WND	72
85411	OPN BRAIN INJ W/O COMA	72
85412	OPN BRAIN INJ-BRIEF COMA	72
85413	OPN BRAIN INJ-MOD COMA	72
85414	OPN BRAIN INJ-PROLN COMA	72
85415	OPN BRAIN INJ-DEEP COMA	72
85416	OPEN BRAIN INJ-COMA NOS	72
85419	OPN BRAIN INJ-CONCUSSION	72
8600	TRAUM PNEUMOTHORAX-CLOSE	72
8601	TRAUM PNEUMOTHORAX-OPEN	72
8602	TRAUM HEMOTHORAX-CLOSED	72
8603	TRAUM HEMOTHORAX-OPEN	72
8604	TRAUM PNEUMOHEMOTHOR-CL	72
8605	TRAUM PNEUMOHEMOTHOR-OPN	72
86100	HEART INJURY NOS-CLOSED	72
86101	HEART CONTUSION-CLOSED	72
86102	HEART LACERATION-CLOSED	72
86103	HEART CHAMBER LACERAT-CL	72
86110	HEART INJURY NOS-OPEN	72
86111	HEART CONTUSION-OPEN	72
86112	HEART LACERATION-OPEN	72
86113	HEART CHAMBER LACER-OPN	72
86120	LUNG INJURY NOS-CLOSED	72
86121	LUNG CONTUSION-CLOSED	72
86122	LUNG LACERATION-CLOSED	72
86130	LUNG INJURY NOS-OPEN	72
86131	LUNG CONTUSION-OPEN	72
86132	LUNG LACERATION-OPEN	72
8620	DIAPHRAGM INJURY-CLOSED	72
8621	DIAPHRAGM INJURY-OPEN	72
86221	BRONCHUS INJURY-CLOSED	72
86222	ESOPHAGUS INJURY-CLOSED	72
86229	INTRATHORACIC INJ NEC-CL	72
86231	BRONCHUS INJURY-OPEN	72
86232	ESOPHAGUS INJURY-OPEN	72
86239	INTRATHORAC INJ NEC-OPEN	72
8628	INTRATHORACIC INJ NOS-CL	72
8629	INTRATHORAC INJ NOS-OPEN	72
8630	STOMACH INJURY-CLOSED	72
8631	STOMACH INJURY-OPEN	72
86320	SMALL INTEST INJ NOS-CL	72
86321	DUODENUM INJURY-CLOSED	72

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
86329	SMALL INTEST INJ NEC-CL	72
86330	SMALL INTEST INJ NOS-OPN	72
86331	DUODENUM INJURY-OPEN	72
86339	SMALL INTEST INJ NEC-OPN	72
86340	COLON INJURY NOS-CLOSED	72
86341	ASCENDING COLON INJ-CLOS	72
86342	TRANSVERSE COLON INJ-CL	72
86343	DESCENDING COLON INJ-CL	72
86344	SIGMOID COLON INJ-CLOSED	72
86345	RECTUM INJURY-CLOSED	72
86346	COLON INJ MULT SITE-CLOS	72
86349	COLON INJURY NEC-CLOSED	72
86350	COLON INJURY NOS-OPEN	72
86351	ASCENDING COLON INJ-OPEN	72
86352	TRANSVERSE COLON INJ-OPN	72
86353	DESCENDING COLON INJ-OPN	72
86354	SIGMOID COLON INJ-OPEN	72
86355	RECTUM INJURY-OPEN	72
86356	COLON INJ MULT SITE-OPEN	72
86359	COLON INJURY NEC-OPEN	72
86380	GI INJURY NOS-CLOSED	72
86381	PANCREAS, HEAD INJ-CLOSE	72
86382	PANCREAS, BODY INJ-CLOSE	72
86383	PANCREAS, TAIL INJ-CLOSE	72
86384	PANCREAS INJURY NOS-CLOS	72
86385	APPENDIX INJURY-CLOSED	72
86389	GI INJURY NEC-CLOSED	72
86390	GI INJURY NOS-OPEN	72
86391	PANCREAS, HEAD INJ-OPEN	72
86392	PANCREAS, BODY INJ-OPEN	72
86393	PANCREAS, TAIL INJ-OPEN	72
86394	PANCREAS INJURY NOS-OPEN	72
86395	APPENDIX INJURY-OPEN	72
86399	GI INJURY NEC-OPEN	72
86400	LIVER INJURY NOS-CLOSED	72
86401	LIVER HEMATOMA/CONTUSION	72
86402	LIVER LACERATION, MINOR	72
86403	LIVER LACERATION, MOD	72
86404	LIVER LACERATION, MAJOR	72
86405	LIVER LACERAT UNSPCF CLS	72
86409	LIVER INJURY NEC-CLOSED	72
86410	LIVER INJURY NOS-OPEN	72
86411	LIVER HEMATOM/CONTUS-OPN	72
86412	LIVER LACERAT, MINOR-OPN	72
86413	LIVER LACERAT, MOD-OPEN	72
86414	LIVER LACERAT, MAJOR-OPN	72
86415	LIVER LACERAT UNSPCF OPN	72
86419	LIVER INJURY NEC-OPEN	72
86500	SPLEEN INJURY NOS-CLOSED	72
86501	SPLEEN HEMATOMA-CLOSED	72
86502	SPLEEN CAPSULAR TEAR	72
86503	SPLEEN PARENCHYMA LACER	72
86504	SPLEEN DISRUPTION-CLOS	72
86509	SPLEEN INJURY NEC-CLOSED	72
86510	SPLEEN INJURY NOS-OPEN	72
86511	SPLEEN HEMATOMA-OPEN	72
86512	SPLEEN CAPSULAR TEAR-OPN	72
86513	SPLEEN PARNCHYM LAC-OPN	72
86514	SPLEEN DISRUPTION-OPEN	72
86519	SPLEEN INJURY NEC-OPEN	72
86600	KIDNEY INJURY NOS-CLOSED	72
86601	KIDNEY HEMATOMA-CLOSED	72
86602	KIDNEY LACERATION-CLOSED	72
86603	KIDNEY DISRUPTION-CLOSED	72
86610	KIDNEY INJURY NOS-OPEN	72
86611	KIDNEY HEMATOMA-OPEN	72
86612	KIDNEY LACERATION-OPEN	72
86613	KIDNEY DISRUPTION-OPEN	72
8670	BLADDER/URETHRA INJ-CLOS	72
8671	BLADDER/URETHRA INJ-OPEN	72
8672	URETER INJURY-CLOSED	72
8673	URETER INJURY-OPEN	72
8674	UTERUS INJURY-CLOSED	72
8675	UTERUS INJURY-OPEN	72
8676	PELVIC ORGAN INJ NEC-CL	72
8677	PELVIC ORGAN INJ NEC-OPN	72

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
8678	PELVIC ORGAN INJ NOS-CL	72
8679	PELVIC ORGAN INJ NOS-OPN	72
86800	INTRA-ABDOM INJ NOS-CLOS	72
86801	ADRENAL GLAND INJURY-CL	72
86802	BILIARY TRACT INJURY-CL	72
86803	PERITONEUM INJURY-CLOSED	72
86804	RETROPERITONEUM INJ-CL	72
86809	INTRA-ABDOM INJ NEC-CLOS	72
86810	INTRA-ABDOM INJ NOS-OPEN	72
86811	ADRENAL GLAND INJURY-OPN	72
86812	BILIARY TRACT INJURY-OPN	72
86813	PERITONEUM INJURY-OPEN	72
86814	RETROPERITONEUM INJ-OPEN	72
86819	INTRA-ABDOM INJ NEC-OPEN	72
8690	INTERNAL INJ NOS-CLOSED	72
8691	INTERNAL INJURY NOS-OPEN	72
8700	LAC EYELID SKN/PERIOCULR	72
8701	FULL-THICKNES LAC EYELID	72
8702	LAC EYELID INV LACRM PAS	72
8703	PENETR WND ORBIT W/O FB	72
8704	PENETRAT WND ORBIT W FB	72
8708	OPN WND OCULAR ADNEX NEC	72
8709	OPN WND OCULAR ADNEX NOS	72
8710	OCULAR LAC W/O PROLAPSE	72
8711	OCULAR LACERA W PROLAPSE	72
8712	RUPTURE EYE W TISSU LOSS	72
8713	AVULSION OF EYE	72
8714	LACERATION OF EYE NOS	72
8715	PENETRAT MAGNET FB EYE	72
8716	PENETRAT FB NEC EYE	72
8717	OCULAR PENETRATION NOS	72
8719	OPN WOUND OF EYEBALL NOS	72
87200	OPN WOUND EXTERN EAR NOS	72
87201	OPEN WOUND OF AURICLE	72
87202	OPN WOUND AUDITORY CANAL	72
87210	OPN WND EX EAR NOS-COMPL	72
87211	OPEN WOUND AURICLE-COMPL	72
87212	OPEN WND AUD CANAL-COMPL	72
87261	OPEN WOUND OF EAR DRUM	72
87262	OPEN WOUND OF OSSICLES	72
87263	OPEN WND EUSTACHIAN TUBE	72
87264	OPEN WOUND OF COCHLEA	72
87269	OPEN WOUND OF EAR NEC	72
87271	OPEN WND EAR DRUM-COMPL	72
87272	OPEN WND OSSICLES-COMPL	72
87273	OPN WND EUSTACH TB-COMPL	72
87274	OPEN WOUND COCHLEA-COMPL	72
87279	OPEN WOUND EAR NEC-COMPL	72
8728	OPEN WOUND OF EAR NOS	72
8729	OPEN WOUND EAR NOS-COMPL	72
8730	OPEN WOUND OF SCALP	72
8731	OPEN WOUND SCALP-COMPL	72
87320	OPEN WOUND OF NOSE NOS	72
87321	OPEN WOUND NASAL SEPTUM	72
87322	OPEN WOUND NASAL CAVITY	72
87323	OPEN WOUND NASAL SINUS	72
87329	MULT OPEN WOUND NOSE	72
87330	OPEN WND NOSE NOS-COMPL	72
87331	OPN WND NAS SEPTUM-COMPL	72
87332	OPEN WND NASAL CAV-COMPL	72
87333	OPEN WND NAS SINUS-COMPL	72
87339	MULT OPEN WND NOSE-COMPL	72
87340	OPEN WOUND OF FACE NOS	72
87341	OPEN WOUND OF CHEEK	72
87342	OPEN WOUND OF FOREHEAD	72
87343	OPEN WOUND OF LIP	72
87344	OPEN WOUND OF JAW	72
87349	OPEN WOUND OF FACE NEC	72
87350	OPEN WND FACE NOS-COMPL	72
87351	OPEN WOUND CHEEK-COMPL	72
87352	OPEN WND FOREHEAD-COMPL	72
87353	OPEN WOUND LIP-COMPLICAT	72
87354	OPEN WOUND JAW-COMPLICAT	72
87359	OPEN WND FACE NEC-COMPL	72
87360	OPEN WOUND OF MOUTH NOS	72
87361	OPEN WOUND BUCCAL MUCOSA	72

*ICD–9 Codes preceded by an asterisk are codes that are not valid as a reason for the visit.

ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
87362	OPEN WOUND OF GUM	72
87363	BROKEN TOOTH	31
87364	OPN WND TONGUE/MOUTH FLR	72
87365	OPEN WOUND OF PALATE	72
87369	OPEN WOUND MOUTH NEC	72
87370	OPEN WND MOUTH NOS-COMPL	72
87371	OPN WND BUC MUCOSA-COMPL	72
87372	OPEN WOUND GUM-COMPL	72
87373	BROKEN TOOTH-COMPLICATED	31
87374	OPEN WOUND TONGUE-COMPL	72
87375	OPEN WOUND PALATE-COMPL	72
87379	OPEN WND MOUTH NOS-COMPL	72
8738	OPEN WOUND OF HEAD NEC	72
8739	OPEN WND HEAD NEC-COMPL	72
87400	OPN WND LARYNX W TRACHEA	72
87401	OPEN WOUND OF LARYNX	72
87402	OPEN WOUND OF TRACHEA	72
87410	OPN WND LARY W TRAC-COMP	72
87411	OPEN WOUND LARYNX-COMPL	72
87412	OPEN WOUND TRACHEA-COMPL	72
8742	OPEN WOUND THYROID GLAND	72
8743	OPEN WOUND THYROID-COMPL	72
8744	OPEN WOUND OF PHARYNX	72
8745	OPEN WOUND PHARYNX-COMPL	72
8748	OPEN WOUND OF NECK NEC	72
8749	OPN WOUND NECK NEC-COMPL	72
8750	OPEN WOUND OF CHEST	72
8751	OPEN WOUND CHEST-COMPL	72
8760	OPEN WOUND OF BACK	72
8761	OPEN WOUND BACK-COMPL	72
8770	OPEN WOUND OF BUTTOCK	72
8771	OPEN WOUND BUTTOCK-COMPL	72
8780	OPEN WOUND OF PENIS	72
8781	OPEN WOUND PENIS-COMPL	72
8782	OPN WOUND SCROTUM/TESTES	72
8783	OPN WND SCROT/TEST-COMPL	72
8784	OPEN WOUND OF VULVA	72
8785	OPEN WOUND VULVA-COMPL	72
8786	OPEN WOUND OF VAGINA	72
8787	OPEN WOUND VAGINA-COMPL	72
8788	OPEN WOUND GENITAL NEC	72
8789	OPN WND GENITAL NEC-COMP	72
8790	OPEN WOUND OF BREAST	72
8791	OPEN WOUND BREAST-COMPL	72
8792	OPN WND ANTERIOR ABDOMEN	72
8793	OPN WND ANT ABDOMEN-COMP	72
8794	OPN WND LATERAL ABDOMEN	72
8795	OPN WND LAT ABDOMEN-COMP	72
8796	OPEN WOUND OF TRUNK NEC	72
8797	OPEN WND TRUNK NEC-COMPL	72
8798	OPEN WOUND SITE NOS	72
8799	OPN WOUND SITE NOS-COMPL	72
88000	OPEN WOUND OF SHOULDER	72
88001	OPEN WOUND OF SCAPULA	72
88002	OPEN WOUND OF AXILLA	72
88003	OPEN WOUND OF UPPER ARM	72
88009	MULT OPEN WOUND SHOULDER	72
88010	OPEN WND SHOULDER-COMPL	72
88011	OPEN WOUND SCAPULA-COMPL	72
88012	OPEN WOUND AXILLA-COMPL	72
88013	OPEN WND UPPER ARM-COMPL	72
88019	MULT OPN WND SHOULD-COMP	72
88020	OPN WND SHOULDR W TENDON	72
88021	OPN WND SCAPULA W TENDON	72
88022	OPEN WND AXILLA W TENDON	72
88023	OPEN WND UP ARM W TENDON	72
88029	MLT OPN WND SHLDR W TEND	72
88100	OPEN WOUND OF FOREARM	72
88101	OPEN WOUND OF ELBOW	72
88102	OPEN WOUND OF WRIST	72
88110	OPEN WOUND FOREARM-COMPL	72
88111	OPEN WOUND ELBOW-COMPLIC	72
88112	OPEN WOUND WRIST-COMPLIC	72
88120	OPEN WND FOREARM W TENDN	72
88121	OPN WOUND ELBOW W TENDON	72
88122	OPN WOUND WRIST W TENDON	72

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
8820	OPEN WOUND OF HAND	72
8821	OPN WOUND HAND-COMPLICAT	72
8822	OPEN WOUND HAND W TENDON	72
8830	OPEN WOUND OF FINGER	72
8831	OPEN WOUND FINGER-COMPL	72
8832	OPEN WND FINGER W TENDON	72
8840	OPEN WOUND ARM MULT/NOS	72
8841	OPEN WOUND ARM NOS-COMPL	72
8842	OPN WND ARM NOS W TENDON	72
8850	AMPUTATION THUMB	72
8851	AMPUTATION THUMB-COMPL	72
8860	AMPUTATION FINGER	72
8861	AMPUTATION FINGER-COMPL	72
8870	AMPUT BELOW ELB, UNILAT	72
8871	AMP BELOW ELB, UNIL-COMP	72
8872	AMPUT ABV ELBOW, UNILAT	72
8873	AMPUT ABV ELB, UNIL-COMP	72
8874	AMPUTAT ARM, UNILAT NOS	72
8875	AMPUT ARM, UNIL NOS-COMP	72
8876	AMPUTATION ARM, BILAT	72
8877	AMPUTAT ARM, BILAT-COMPL	72
8900	OPEN WOUND OF HIP/THIGH	72
8901	OPEN WND HIP/THIGH-COMPL	72
8902	OPN WND HIP/THIGH W TEND	72
8910	OPEN WND KNEE/LEG/ANKLE	72
8911	OPEN WND KNEE/LEG-COMPL	72
8912	OPN WND KNEE/LEG W TENDN	72
8920	OPEN WOUND OF FOOT	72
8921	OPEN WOUND FOOT-COMPL	72
8922	OPEN WOUND FOOT W TENDON	72
8930	OPEN WOUND OF TOE	72
8931	OPEN WOUND TOE-COMPL	72
8932	OPEN WOUND TOE W TENDON	72
8940	OPEN WOUND OF LEG NEC	72
8941	OPEN WOUND LEG NEC-COMPL	72
8942	OPN WND LEG NEC W TENDON	72
8950	AMPUTATION TOE	72
8951	AMPUTATION TOE-COMPLICAT	72
8960	AMPUTATION FOOT, UNILAT	72
8961	AMPUT FOOT, UNILAT-COMPL	72
8962	AMPUTATION FOOT, BILAT	72
8963	AMPUTAT FOOT, BILAT-COMP	72
8970	AMPUT BELOW KNEE, UNILAT	72
8971	AMPUTAT BK, UNILAT-COMPL	72
8972	AMPUT ABOVE KNEE, UNILAT	72
8973	AMPUT ABV KN, UNIL-COMPL	72
8974	AMPUTAT LEG, UNILAT NOS	72
8975	AMPUT LEG, UNIL NOS-COMP	72
8976	AMPUTATION LEG, BILAT	72
8977	AMPUTAT LEG, BILAT-COMPL	72
90000	INJUR CAROTID ARTERY NOS	72
90001	INJ COMMON CAROTID ARTER	72
90002	INJ EXTERNAL CAROTID ART	72
90003	INJ INTERNAL CAROTID ART	72
9001	INJ INTERNL JUGULAR VEIN	72
90081	INJ EXTERN JUGULAR VEIN	72
90082	INJ MLT HEAD/NECK VESSEL	72
90089	INJ HEAD/NECK VESSEL NEC	72
9009	INJ HEAD/NECK VESSEL NOS	72
9010	INJURY THORACIC AORTA	72
9011	INJ INNOMIN/SUBCLAV ART	72
9012	INJ SUPERIOR VENA CAVA	72
9013	INJ INNOMIN/SUBCLAV VEIN	72
90140	INJ PULMONARY VESSEL NOS	72
90141	INJURY PULMONARY ARTERY	72
90142	INJURY PULMONARY VEIN	72
90181	INJ INTERCOSTAL ART/VEIN	72
90182	INJ INT MAMMARY ART/VEIN	72
90183	INJ MULT THORACIC VESSEL	72
90189	INJ THORACIC VESSEL NEC	72
9019	INJ THORACIC VESSEL NOS	72
9020	INJURY ABDOMINAL AORTA	72
90210	INJ INFER VENA CAVA NOS	72
90211	INJURY HEPATIC VEINS	72
90219	INJ INFER VENA CAVA NEC	72
90220	INJ CELIAC/MESEN ART NOS	72

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
90221	INJURY GASTRIC ARTERY	72
90222	INJURY HEPATIC ARTERY	72
90223	INJURY SPLENIC ARTERY	72
90224	INJURY CELIAC AXIS NEC	72
90225	INJ SUPER MESENTERIC ART	72
90226	INJ BRNCH SUP MESENT ART	72
90227	INJ INFER MESENTERIC ART	72
90229	INJ MESENTERIC VESS NEC	72
90231	INJ SUPERIOR MESENT VEIN	72
90232	INJ INFERIOR MESENT VEIN	72
90233	INJURY PORTAL VEIN	72
90234	INJURY SPLENIC VEIN	72
90239	INJ PORT/SPLEN VESS NEC	72
90240	INJURY RENAL VESSEL NOS	72
90241	INJURY RENAL ARTERY	72
90242	INJURY RENAL VEIN	72
90249	INJURY RENAL VESSEL NEC	72
90250	INJURY ILIAC VESSEL NOS	72
90251	INJ HYPOGASTRIC ARTERY	72
90252	INJURY HYPOGASTRIC VEIN	72
90253	INJURY ILIAC ARTERY	72
90254	INJURY ILIAC VEIN	72
90255	INJURY UTERINE ARTERY	72
90256	INJURY UTERINE VEIN	72
90259	INJURY ILIAC VESSEL NEC	72
90281	INJURY OVARIAN ARTERY	72
90282	INJURY OVARIAN VEIN	72
90287	INJ MULT ABD/PELV VESSEL	72
90289	INJ ABDOMINAL VESSEL NEC	72
9029	INJ ABDOMINAL VESSEL NOS	72
90300	INJ AXILLARY VESSEL NOS	72
90301	INJURY AXILLARY ARTERY	72
90302	INJURY AXILLARY VEIN	72
9031	INJURY BRACHIAL VESSELS	72
9032	INJURY RADIAL VESSELS	72
9033	INJURY ULNAR VESSELS	72
9034	INJURY PALMAR ARTERY	72
9035	INJURY FINGER VESSELS	72
9038	INJURY ARM VESSELS NEC	72
9039	INJURY ARM VESSEL NOS	72
9040	INJ COMMON FEMORAL ARTER	72
9041	INJ SUPERFIC FEMORAL ART	72
9042	INJURY FEMORAL VEIN	72
9043	INJURY SAPHENOUS VEIN	72
90440	INJ POPLITEAL VESSEL NOS	72
90441	INJURY POPLITEAL ARTERY	72
90442	INJURY POPLITEAL VEIN	72
90450	INJURY TIBIAL VESSEL NOS	72
90451	INJ ANTER TIBIAL ARTERY	72
90452	INJ ANTERIOR TIBIAL VEIN	72
90453	INJ POST TIBIAL ARTERY	72
90454	INJ POST TIBIAL VEIN	72
9046	INJ DEEP PLANTAR VESSEL	72
9047	INJURY LEG VESSELS NEC	72
9048	INJURY LEG VESSEL NOS	72
9049	BLOOD VESSEL INJURY NOS	72
9050	LATE EFFEC SKULL/FACE FX	72
9051	LATE EFF SPINE/TRUNK FX	72
9052	LATE EFFECT ARM FX	72
9053	LATE EFF FEMORAL NECK FX	72
9054	LATE EFFECT LEG FX	72
9055	LATE EFFECT FRACTURE NEC	72
9056	LATE EFFECT DISLOCATION	72
9057	LATE EFFEC SPRAIN/STRAIN	72
9058	LATE EFFEC TENDON INJURY	72
9059	LATE EFF TRAUMAT AMPUTAT	72
9060	LT EFF OPN WND HEAD/TRNK	72
9061	LATE EFF OPEN WND EXTREM	72
9062	LATE EFF SUPERFICIAL INJ	72
9063	LATE EFFECT OF CONTUSION	72
9064	LATE EFFECT OF CRUSHING	72
9065	LATE EFF HEAD/NECK BURN	72
9066	LATE EFF WRIST/HAND BURN	72
9067	LATE EFF BURN EXTREM NEC	72
9068	LATE EFFECT OF BURNS NEC	72
9069	LATE EFFECT OF BURN NOS	72

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
9070	LT EFF INTRACRANIAL INJ	72
9071	LATE EFF CRAN NERVE INJ	72
9072	LATE EFF SPINAL CORD INJ	72
9073	LT EFF NERV INJ TRNK NEC	72
9074	LT EFF NERV INJ SHLD/ARM	72
9075	LT EFF NERV INJ PELV/LEG	72
9079	LATE EFF NERVE INJ NEC	72
9080	LATE EFF INT INJUR CHEST	72
9081	LATE EFF INT INJ ABDOMEN	72
9082	LATE EFF INT INJURY NEC	72
9083	LATE EFF INJ PERIPH VESS	72
9084	LT EFF INJ THOR/ABD VESS	72
9085	LATE EFF FB IN ORIFICE	72
9086	LATE EFF COMPLIC TRAUMA	72
9089	LATE EFFECT INJURY NOS	72
9090	LATE EFF DRUG POISONING	72
9091	LATE EFF NONMED SUBSTANC	72
9092	LATE EFFECT OF RADIATION	72
9093	LATE EFF SURG/MED COMPL	11
9094	LATE EFF CERT EXT CAUSE	72
9095	LTE EFCT ADVRS EFCT DRUG	11
9099	LATE EFF EXTER CAUSE NEC	72
9100	ABRASION HEAD	72
9101	ABRASION HEAD-INFECTED	72
9102	BLISTER HEAD	72
9103	BLISTER HEAD-INFECTED	72
9104	INSECT BITE HEAD	72
9105	INSECT BITE HEAD-INFECT	72
9106	FOREIGN BODY HEAD	72
9107	FOREIGN BODY HEAD-INFECT	72
9108	SUPERFIC INJ HEAD NEC	72
9109	SUPERF INJ HEAD NEC-INF	72
9110	ABRASION TRUNK	72
9111	ABRASION TRUNK-INFECTED	72
9112	BLISTER TRUNK	72
9113	BLISTER TRUNK-INFECTED	72
9114	INSECT BITE TRUNK	72
9115	INSECT BITE TRUNK-INFEC	72
9116	FOREIGN BODY TRUNK	72
9117	FOREIGN BODY TRUNK-INFEC	72
9118	SUPERFIC INJ TRUNK NEC	72
9119	SUPERF INJ TRNK NEC-INF	72
9120	ABRASION SHOULDER/ARM	72
9121	ABRASION SHLDR/ARM-INFEC	72
9122	BLISTER SHOULDER & ARM	72
9123	BLISTER SHOULDER/ARM-INF	72
9124	INSECT BITE SHOULDER/ARM	72
9125	INSECT BITE SHLD/ARM-INF	72
9126	FOREIGN BODY SHOULDR/ARM	72
9127	FB SHOULDER/ARM-INFECT	72
9128	SUPERF INJ SHLDR/ARM NEC	72
9129	SUPERF INJ SHLDR NEC-INF	72
9130	ABRASION FOREARM	72
9131	ABRASION FOREARM-INFECT	72
9132	BLISTER FOREARM	72
9133	BLISTER FOREARM-INFECTED	72
9134	INSECT BITE FOREARM	72
9135	INSECT BITE FOREARM-INF	72
9136	FOREIGN BODY FOREARM	72
9137	FOREIGN BODY FOREARM-INF	72
9138	SUPERF INJ FOREARM NEC	72
9139	SUPRF INJ FORARM NEC-INF	72
9140	ABRASION HAND	72
9141	ABRASION HAND-INFECTED	72
9142	BLISTER HAND	72
9143	BLISTER HAND-INFECTED	72
9144	INSECT BITE HAND	72
9145	INSECT BITE HAND-INFECT	72
9146	FOREIGN BODY HAND	72
9147	FOREIGN BODY HAND-INFECT	72
9148	SUPERFICIAL INJ HAND NEC	72
9149	SUPERF INJ HAND NEC-INF	72
9150	ABRASION FINGER	72
9151	ABRASION FINGER-INFECTED	72
9152	BLISTER FINGER	72
9153	BLISTER FINGER-INFECTED	72

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
9154	INSECT BITE FINGER	72
9155	INSECT BITE FINGER-INFEC	72
9156	FOREIGN BODY FINGER	72
9157	FOREIGN BODY FINGER-INF	72
9158	SUPERFIC INJ FINGER-NEC	72
9159	SUPRF INJ FINGER NEC-INF	72
9160	ABRASION HIP & LEG	72
9161	ABRASION HIP/LEG-INFECT	72
9162	BLISTER HIP & LEG	72
9163	BLISTER HIP & LEG-INFECT	72
9164	INSECT BITE HIP & LEG	72
9165	INSECT BITE HIP/LEG-INF	72
9166	FOREIGN BODY HIP/LEG	72
9167	FOREIGN BDY HIP/LEG-INF	72
9168	SUPERFIC INJ HIP/LEG NEC	72
9169	SUPERF INJ LEG NEC-INFEC	72
9170	ABRASION FOOT & TOE	72
9171	ABRASION FOOT/TOE-INFEC	72
9172	BLISTER FOOT & TOE	72
9173	BLISTER FOOT & TOE-INFEC	72
9174	INSECT BITE FOOT/TOE	72
9175	INSECT BITE FOOT/TOE-INF	72
9176	FOREIGN BODY FOOT & TOE	72
9177	FOREIGN BDY FOOT/TOE-INF	72
9178	SUPERF INJ FOOT/TOE NEC	72
9179	SUPERF INJ FOOT NEC-INF	72
9180	SUPERFIC INJ PERIOCULAR	68
9181	SUPERFICIAL INJ CORNEA	68
9182	SUPERFIC INJ CONJUNCTIVA	68
9189	SUPERFICIAL INJ EYE NEC	68
9190	ABRASION NEC	72
9191	ABRASION NEC-INFECTED	72
9192	BLISTER NEC	72
9193	BLISTER NEC-INFECTED	72
9194	INSECT BITE NEC	72
9195	INSECT BITE NEC-INFECTED	72
9196	SUPERFIC FOREIGN BDY NEC	72
9197	SUPERFICIAL FB NEC-INFEC	72
9198	SUPERFICIAL INJURY NEC	72
9199	SUPERFIC INJ NEC-INFECT	72
920	CONTUSION FACE/SCALP/NCK	72
9210	BLACK EYE NOS	72
9211	CONTUSION PERIOCULAR	72
9212	CONTUSION ORBITAL TISSUE	72
9213	CONTUSION OF EYEBALL	72
9219	CONTUSION OF EYE NOS	68
9220	CONTUSION OF BREAST	72
9221	CONTUSION OF CHEST WALL	72
9222	CONTUSION ABDOMINAL WALL	72
9224	CONTUSION GENITAL ORGANS	72
9228	MULTIPLE CONTUSION TRUNK	72
9229	CONTUSION TRUNK NOS	72
92300	CONTUSION SHOULDER REG	72
92301	CONTUSION SCAPUL REGION	72
92302	CONTUSION AXILLARY REG	72
92303	CONTUSION OF UPPER ARM	72
92309	CONTUSION SHOULDER & ARM	72
92310	CONTUSION OF FOREARM	72
92311	CONTUSION OF ELBOW	72
92320	CONTUSION OF HAND(S)	72
92321	CONTUSION OF WRIST	72
9233	CONTUSION OF FINGER	72
9238	MULTIPLE CONTUSION ARM	72
9239	CONTUSION UPPER LIMB NOS	72
92400	CONTUSION OF THIGH	72
92401	CONTUSION OF HIP	72
92410	CONTUSION OF LOWER LEG	72
92411	CONTUSION OF KNEE	72
92420	CONTUSION OF FOOT	72
92421	CONTUSION OF ANKLE	72
9243	CONTUSION OF TOE	72
9244	MULTIPLE CONTUSION LEG	72
9245	CONTUSION LEG NOS	72
9248	MULTIPLE CONTUSIONS NEC	72
9249	CONTUSION NOS	72
9251	CRUSH INJ FACE SCALP	72

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
9252	CRUSH INJ NECK	72
9260	CRUSH INJ EXT GENITALIA	72
92611	CRUSHING INJURY BACK	72
92612	CRUSHING INJURY BUTTOCK	72
92619	CRUSHING INJ TRUNK NEC	72
9268	MULT CRUSHING INJ TRUNK	72
9269	CRUSHING INJ TRUNK NOS	72
92700	CRUSH INJ SHOULDER REG	72
92701	CRUSH INJ SCAPUL REGION	72
92702	CRUSH INJ AXILLARY REG	72
92703	CRUSHING INJ UPPER ARM	72
92709	CRUSH INJ SHOULDER & ARM	72
92710	CRUSHING INJURY FOREARM	72
92711	CRUSHING INJURY ELBOW	72
92720	CRUSHING INJURY OF HAND	72
92721	CRUSHING INJURY OF WRIST	72
9273	CRUSHING INJURY FINGER	72
9278	MULT CRUSHING INJURY ARM	72
9279	CRUSHING INJURY ARM NOS	72
92800	CRUSHING INJURY THIGH	72
92801	CRUSHING INJURY HIP	72
92810	CRUSHING INJ LOWER LEG	72
92811	CRUSHING INJURY KNEE	72
92820	CRUSHING INJURY FOOT	72
92821	CRUSHING INJURY ANKLE	72
9283	CRUSHING INJURY TOE	72
9288	MULT CRUSHING INJURY LEG	72
9289	CRUSHING INJURY LEG NOS	72
9290	CRUSH INJ MULT SITE NEC	72
9299	CRUSHING INJURY NOS	72
9300	CORNEAL FOREIGN BODY	68
9301	FB IN CONJUNCTIVAL SAC	72
9302	FB IN LACRIMAL PUNCTUM	72
9308	FOREIGN BDY EXT EYE NEC	68
9309	FOREIGN BDY EXT EYE NOS	68
931	FOREIGN BODY IN EAR	72
932	FOREIGN BODY IN NOSE	72
9330	FOREIGN BODY IN PHARYNX	72
9331	FOREIGN BODY IN LARYNX	72
9340	FOREIGN BODY IN TRACHEA	72
9341	FOREIGN BODY BRONCHUS	72
9348	FB TRACH/BRONCH/LUNG NEC	72
9349	FB RESPIRATORY TREE NOS	72
9350	FOREIGN BODY IN MOUTH	72
9351	FOREIGN BODY ESOPHAGUS	72
9352	FOREIGN BODY IN STOMACH	72
936	FB IN INTESTINE & COLON	72
937	FOREIGN BODY ANUS/RECTUM	72
938	FOREIGN BODY GI NOS	72
9390	FB BLADDER & URETHRA	72
9391	FOREIGN BODY UTERUS	56
9392	FOREIGN BDY VULVA/VAGINA	72
9393	FOREIGN BODY PENIS	72
9399	FOREIGN BDY GU TRACT NOS	72
9400	CHEMICAL BURN PERIOCULAR	72
9401	BURN PERIOCULAR AREA NEC	72
9402	ALKAL BURN CORNEA/CONJUN	72
9403	ACID BURN CORNEA/CONJUNC	72
9404	BURN CORNEA/CONJUNCT NEC	72
9405	BURN W EYEBALL DESTRUCT	72
9409	BURN EYE & ADNEXA NOS	72
94100	BURN NOS HEAD-UNSPEC	72
94101	BURN NOS EAR	72
94102	BURN NOS EYE	72
94103	BURN NOS LIP	72
94104	BURN NOS CHIN	72
94105	BURN NOS NOSE	72
94106	BURN NOS SCALP	72
94107	BURN NOS FACE NEC	72
94108	BURN NOS NECK	72
94109	BURN NOS HEAD-MULT	72
94110	1ST DEG BURN HEAD NOS	72
94111	1ST DEG BURN EAR	72
94112	1ST DEG BURN EYE	72
94113	1ST DEG BURN LIP	72
94114	1ST DEG BURN CHIN	72

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
94115	1ST DEG BURN NOSE	72
94116	1ST DEG BURN SCALP	72
94117	1ST DEG BURN FACE NEC	72
94118	1ST DEG BURN NECK	72
94119	1ST DEG BURN HEAD-MULT	72
94120	2ND DEG BURN HEAD NOS	72
94121	2ND DEG BURN EAR	72
94122	2ND DEG BURN EYE	72
94123	2ND DEG BURN LIP	72
94124	2ND DEG BURN CHIN	72
94125	2ND DEG BURN NOSE	72
94126	2ND DEG BURN SCALP	72
94127	2ND DEG BURN FACE NEC	72
94128	2ND DEG BURN NECK	72
94129	2ND DEG BURN HEAD-MULT	72
94130	3RD DEG BURN HEAD NOS	72
94131	3RD DEG BURN EAR	72
94132	3RD DEG BURN EYE	72
94133	3RD DEG BURN LIP	72
94134	3RD DEG BURN CHIN	72
94135	3RD DEG BURN NOSE	72
94136	3RD DEG BURN SCALP	72
94137	3RD DEG BURN FACE NEC	72
94138	3RD DEG BURN NECK	72
94139	3RD DEG BURN HEAD-MULT	72
94140	DEEP 3 DEG BURN HEAD NOS	72
94141	DEEP 3RD DEG BURN EAR	72
94142	DEEP 3RD DEG BURN EYE	72
94143	DEEP 3RD DEG BURN LIP	72
94144	DEEP 3RD DEG BURN CHIN	72
94145	DEEP 3RD DEG BURN NOSE	72
94146	DEEP 3RD DEG BURN SCALP	72
94147	DEEP 3RD BURN FACE NEC	72
94148	DEEP 3RD DEG BURN NECK	72
94149	DEEP 3 DEG BRN HEAD-MULT	72
94150	3RD BURN W LOSS-HEAD NOS	72
94151	3RD DEG BURN W LOSS-EAR	72
94152	3RD DEG BURN W LOSS-EYE	72
94153	3RD DEG BURN W LOSS-LIP	72
94154	3RD DEG BURN W LOSS-CHIN	72
94155	3RD DEG BURN W LOSS-NOSE	72
94156	3RD DEG BRN W LOSS-SCALP	72
94157	3RD BURN W LOSS-FACE NEC	72
94158	3RD DEG BURN W LOSS-NECK	72
94159	3RD BRN W LOSS-HEAD MULT	72
94200	BURN NOS TRUNK-UNSPEC	72
94201	BURN NOS BREAST	72
94202	BURN NOS CHEST WALL	72
94203	BURN NOS ABDOMINAL WALL	72
94204	BURN NOS BACK	72
94205	BURN NOS GENITALIA	72
94209	BURN NOS TRUNK NEC	72
94210	1ST DEG BURN TRUNK NOS	72
94211	1ST DEG BURN BREAST	72
94212	1ST DEG BURN CHEST WALL	72
94213	1ST DEG BURN ABDOMN WALL	72
94214	1ST DEG BURN BACK	72
94215	1ST DEG BURN GENITALIA	72
94219	1ST DEG BURN TRUNK NEC	72
94220	2ND DEG BURN TRUNK NOS	72
94221	2ND DEG BURN BREAST	72
94222	2ND DEG BURN CHEST WALL	72
94223	2ND DEG BURN ABDOMN WALL	72
94224	2ND DEG BURN BACK	72
94225	2ND DEG BURN GENITALIA	72
94229	2ND DEG BURN TRUNK NEC	72
94230	3RD DEG BURN TRUNK NOS	72
94231	3RD DEG BURN BREAST	72
94232	3RD DEG BURN CHEST WALL	72
94233	3RD DEG BURN ABDOMN WALL	72
94234	3RD DEG BURN BACK	72
94235	3RD DEG BURN GENITALIA	72
94239	3RD DEG BURN TRUNK NEC	72
94240	DEEP 3RD BURN TRUNK NOS	72
94241	DEEP 3RD DEG BURN BREAST	72
94242	DEEP 3RD BURN CHEST WALL	72

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
94243	DEEP 3RD BURN ABDOM WALL	72
94244	DEEP 3RD DEG BURN BACK	72
94245	DEEP 3RD BURN GENITALIA	72
94249	DEEP 3RD BURN TRUNK NEC	72
94250	3RD BRN W LOSS-TRUNK NOS	72
94251	3RD BURN W LOSS-BREAST	72
94252	3RD BRN W LOSS-CHEST WLL	72
94253	3RD BRN W LOSS-ABDOM WLL	72
94254	3RD DEG BURN W LOSS-BACK	72
94255	3RD BRN W LOSS-GENITALIA	72
94259	3RD BRN W LOSS-TRUNK NEC	72
94300	BURN NOS ARM-UNSPEC	72
94301	BURN NOS FOREARM	72
94302	BURN NOS ELBOW	72
94303	BURN NOS UPPER ARM	72
94304	BURN NOS AXILLA	72
94305	BURN NOS SHOULDER	72
94306	BURN NOS SCAPULA	72
94309	BURN NOS ARM-MULTIPLE	72
94310	1ST DEG BURN ARM NOS	72
94311	1ST DEG BURN FOREARM	72
94312	1ST DEG BURN ELBOW	72
94313	1ST DEG BURN UPPER ARM	72
94314	1ST DEG BURN AXILLA	72
94315	1ST DEG BURN SHOULDER	72
94316	1ST DEG BURN SCAPULA	72
94319	1ST DEG BURN ARM-MULT	72
94320	2ND DEG BURN ARM NOS	72
94321	2ND DEG BURN FOREARM	72
94322	2ND DEG BURN ELBOW	72
94323	2ND DEG BURN UPPER ARM	72
94324	2ND DEG BURN AXILLA	72
94325	2ND DEG BURN SHOULDER	72
94326	2ND DEG BURN SCAPULA	72
94329	2ND DEG BURN ARM-MULT	72
94330	3RD DEG BURN ARM NOS	72
94331	3RD DEG BURN FOREARM	72
94332	3RD DEG BURN ELBOW	72
94333	3RD DEG BURN UPPER ARM	72
94334	3RD DEG BURN AXILLA	72
94335	3RD DEG BURN SHOULDER	72
94336	3RD DEG BURN SCAPULA	72
94339	3RD DEG BURN ARM-MULT	72
94340	DEEP 3 DEG BURN ARM NOS	72
94341	DEEP 3 DEG BURN FOREARM	72
94342	DEEP 3 DEG BURN ELBOW	72
94343	DEEP 3 DEG BRN UPPER ARM	72
94344	DEEP 3 DEG BURN AXILLA	72
94345	DEEP 3 DEG BURN SHOULDER	72
94346	DEEP 3 DEG BURN SCAPULA	72
94349	DEEP 3 DEG BURN ARM-MULT	72
94350	3RD BURN W LOSS-ARM NOS	72
94351	3RD BURN W LOSS-FOREARM	72
94352	3RD BURN W LOSS-ELBOW	72
94353	3RD BRN W LOSS-UPPER ARM	72
94354	3RD BURN W LOSS-AXILLA	72
94355	3RD BURN W LOSS-SHOULDER	72
94356	3RD BURN W LOSS-SCAPULA	72
94359	3RD BURN W LOSS ARM-MULT	72
94400	BURN NOS HAND-UNSPEC	72
94401	BURN NOS FINGER	72
94402	BURN NOS THUMB	72
94403	BURN NOS MULT FINGERS	72
94404	BURN NOS FINGER W THUMB	72
94405	BURN NOS PALM	72
94406	BURN NOS BACK OF HAND	72
94407	BURN NOS WRIST	72
94408	BURN NOS HAND-MULTIPLE	72
94410	1ST DEG BURN HAND NOS	72
94411	1ST DEG BURN FINGER	72
94412	1ST DEG BURN THUMB	72
94413	1ST DEG BURN MULT FINGER	72
94414	1 DEG BURN FINGR W THUMB	72
94415	1ST DEG BURN PALM	72
94416	1 DEG BURN BACK OF HAND	72
94417	1ST DEG BURN WRIST	72

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
94418	1ST DEG BURN HAND-MULT	72
94420	2ND DEG BURN HAND NOS	72
94421	2ND DEG BURN FINGER	72
94422	2ND DEG BURN THUMB	72
94423	2ND DEG BURN MULT FINGER	72
94424	2 DEG BURN FINGR W THUMB	72
94425	2ND DEG BURN PALM	72
94426	2 DEG BURN BACK OF HAND	72
94427	2ND DEG BURN WRIST	72
94428	2ND DEG BURN HAND-MULT	72
94430	3RD DEG BURN HAND NOS	72
94431	3RD DEG BURN FINGER	72
94432	3RD DEG BURN THUMB	72
94433	3RD DEG BURN MULT FINGER	72
94434	3 DEG BURN FINGR W THUMB	72
94435	3RD DEG BURN PALM	72
94436	3 DEG BURN BACK OF HAND	72
94437	3RD DEG BURN WRIST	72
94438	3RD DEG BURN HAND-MULT	72
94440	DEEP 3 DEG BRN HAND NOS	72
94441	DEEP 3 DEG BURN FINGER	72
94442	DEEP 3 DEG BURN THUMB	72
94443	DEEP 3RD BRN MULT FINGER	72
94444	DEEP 3RD BRN FNGR W THMB	72
94445	DEEP 3 DEG BURN PALM	72
94446	DEEP 3RD BRN BACK OF HND	72
94447	DEEP 3 DEG BURN WRIST	72
94448	DEEP 3 DEG BRN HAND-MULT	72
94450	3RD BRN W LOSS-HAND NOS	72
94451	3RD BURN W LOSS-FINGER	72
94452	3RD BURN W LOSS-THUMB	72
94453	3RD BRN W LOSS-MULT FNGR	72
94454	3RD BRN W LOSS-FNGR/THMB	72
94455	3RD BURN W LOSS-PALM	72
94456	3RD BRN W LOSS-BK OF HND	72
94457	3RD BURN W LOSS-WRIST	72
94458	3RD BRN W LOSS HAND-MULT	72
94500	BURN NOS LEG-UNSPEC	72
94501	BURN NOS TOE	72
94502	BURN NOS FOOT	72
94503	BURN NOS ANKLE	72
94504	BURN NOS LOWER LEG	72
94505	BURN NOS KNEE	72
94506	BURN NOS THIGH	72
94509	BURN NOS LEG-MULTIPLE	72
94510	1ST DEG BURN LEG NOS	72
94511	1ST DEG BURN TOE	72
94512	1ST DEG BURN FOOT	72
94513	1ST DEG BURN ANKLE	72
94514	1ST DEG BURN LOWER LEG	72
94515	1ST DEG BURN KNEE	72
94516	1ST DEG BURN THIGH	72
94519	1ST DEG BURN LEG-MULT	72
94520	2ND DEG BURN LEG NOS	72
94521	2ND DEG BURN TOE	72
94522	2ND DEG BURN FOOT	72
94523	2ND DEG BURN ANKLE	72
94524	2ND DEG BURN LOWER LEG	72
94525	2ND DEG BURN KNEE	72
94526	2ND DEG BURN THIGH	72
94529	2ND DEG BURN LEG-MULT	72
94530	3RD DEG BURN LEG NOS	72
94531	3RD DEG BURN TOE	72
94532	3RD DEG BURN FOOT	72
94533	3RD DEG BURN ANKLE	72
94534	3RD DEG BURN LOW LEG	72
94535	3RD DEG BURN KNEE	72
94536	3RD DEG BURN THIGH	72
94539	3RD DEG BURN LEG-MULT	72
94540	DEEP 3RD DEG BRN LEG NOS	72
94541	DEEP 3RD DEG BURN TOE	72
94542	DEEP 3RD DEG BURN FOOT	72
94543	DEEP 3RD DEG BURN ANKLE	72
94544	DEEP 3RD DEG BRN LOW LEG	72
94545	DEEP 3RD DEG BURN KNEE	72
94546	DEEP 3RD DEG BURN THIGH	72

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
94549	DEEP 3 DEG BURN LEG-MULT	72
94550	3 DEG BRN W LOSS-LEG NOS	72
94551	3 DEG BURN W LOSS-TOE	72
94552	3 DEG BURN W LOSS-FOOT	72
94553	3 DEG BURN W LOSS-ANKLE	72
94554	3 DEG BRN W LOSS-LOW LEG	72
94555	3 DEG BURN W LOSS-KNEE	72
94556	3 DEG BURN W LOSS-THIGH	72
94559	3 DEG BRN W LOSS LEG-MLT	72
9460	BURN NOS MULTIPLE SITE	72
9461	1ST DEG BURN MULT SITE	72
9462	2ND DEG BURN MULT SITE	72
9463	3RD DEG BURN MULT SITE	72
9464	DEEP 3 DEG BRN MULT SITE	72
9465	3RD BRN W LOSS-MULT SITE	72
9470	BURN OF MOUTH & PHARYNX	72
9471	BURN LARYNX/TRACHEA/LUNG	72
9472	BURN OF ESOPHAGUS	72
9473	BURN OF GI TRACT	72
9474	BURN OF VAGINA & UTERUS	72
9478	BURN INTERNAL ORGAN NEC	72
9479	BURN INTERNAL ORGAN NOS	72
94800	BDY BRN < 10%/3D DEG NOS	72
94810	10-19% BDY BRN/3 DEG NOS	72
94811	10-19% BDY BRN/10-19% 3D	72
94820	20-29% BDY BRN/3 DEG NOS	72
94821	20-29% BDY BRN/10-19% 3D	72
94822	20-29% BDY BRN/20-29% 3D	72
94830	30-39% BDY BRN/3 DEG NOS	72
94831	30-39% BDY BRN/10-19% 3D	72
94832	30-39% BDY BRN/20-29% 3D	72
94833	30-39% BDY BRN/30-39% 3D	72
94840	40-49% BDY BRN/3 DEG NOS	72
94841	40-49% BDY BRN/10-19% 3D	72
94842	40-49% BDY BRN/20-29% 3D	72
94843	40-49% BDY BRN/30-39% 3D	72
94844	40-49% BDY BRN/40-49% 3D	72
94850	50-59% BDY BRN/3 DEG NOS	72
94851	50-59% BDY BRN/10-19% 3D	72
94852	50-59% BDY BRN/20-29% 3D	72
94853	50-59% BDY BRN/30-39% 3D	72
94854	50-59% BDY BRN/40-49% 3D	72
94855	50-59% BDY BRN/50-59% 3D	72
94860	60-69% BDY BRN/3 DEG NOS	72
94861	60-69% BDY BRN/10-19% 3D	72
94862	60-69% BDY BRN/20-29% 3D	72
94863	60-69% BDY BRN/30-39% 3D	72
94864	60-69% BDY BRN/40-49% 3D	72
94865	60-69% BDY BRN/50-59% 3D	72
94866	60-69% BDY BRN/60-69% 3D	72
94870	70-79% BDY BRN/3 DEG NOS	72
94871	70-79% BDY BRN/10-19% 3D	72
94872	70-79% BDY BRN/20-29% 3D	72
94873	70-79% BDY BRN/30-39% 3D	72
94874	70-79% BDY BRN/40-49% 3D	72
94875	70-79% BDY BRN/50-59% 3D	72
94876	70-79% BDY BRN/60-69% 3D	72
94877	70-79% BDY BRN/70-79% 3D	72
94880	80-89% BDY BRN/3 DEG NOS	72
94881	80-89% BDY BRN/10-19% 3D	72
94882	80-89% BDY BRN/20-29% 3D	72
94883	80-89% BDY BRN/30-39% 3D	72
94884	80-89% BDY BRN/40-49% 3D	72
94885	80-89% BDY BRN/50-59% 3D	72
94886	80-89% BDY BRN/60-69% 3D	72
94887	80-89% BDY BRN/70-79% 3D	72
94888	80-89% BDY BRN/80-89% 3D	72
94890	90% + BDY BRN/3D DEG NOS	72
94891	90% + BDY BRN/10-19% 3RD	72
94892	90% + BDY BRN/20-29% 3RD	72
94893	90% + BDY BRN/30-39% 3RD	72
94894	90% + BDY BRN/40-49% 3RD	72
94895	90% + BDY BRN/50-59% 3RD	72
94896	90% + BDY BRN/60-69% 3RD	72
94897	90% + BDY BRN/70-79% 3RD	72
94898	90% + BDY BRN/80-89% 3RD	72

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
94899	90% + BDY BRN/90% + 3RD	72
9490	BURN NOS	72
9491	1ST DEGREE BURN NOS	72
9492	2ND DEGREE BURN NOS	72
9493	3RD DEGREE BURN NOS	72
9494	DEEP 3RD DEG BURN NOS	72
9495	3RD BURN W LOSS-SITE NOS	72
9500	OPTIC NERVE INJURY	72
9501	INJURY TO OPTIC CHIASM	72
9502	INJURY TO OPTIC PATHWAYS	72
9503	INJURY TO VISUAL CORTEX	72
9509	INJ OPTIC NERV/PATH NOS	72
9510	INJURY OCULOMOTOR NERVE	72
9511	INJURY TROCHLEAR NERVE	72
9512	INJURY TRIGEMINAL NERVE	72
9513	INJURY ABDUCENS NERVE	72
9514	INJURY TO FACIAL NERVE	72
9515	INJURY TO ACOUSTIC NERVE	72
9516	INJURY ACCESSORY NERVE	72
9517	INJURY HYPOGLOSSAL NERVE	72
9518	INJURY CRANIAL NERVE NEC	72
9519	INJURY CRANIAL NERVE NOS	72
95200	C1-C4 SPIN CORD INJ NOS	72
95201	COMPLETE LES CORD/C1-C4	72
95202	ANTERIOR CORD SYND/C1-C4	72
95203	CENTRAL CORD SYND/C1-C4	72
95204	C1-C4 SPIN CORD INJ NEC	72
95205	C5-C7 SPIN CORD INJ NOS	72
95206	COMPLETE LES CORD/C5-C7	72
95207	ANTERIOR CORD SYND/C5-C7	72
95208	CENTRAL CORD SYND/C5-C7	72
95209	C5-C7 SPIN CORD INJ NEC	72
95210	T1-T6 SPIN CORD INJ NOS	72
95211	COMPLETE LES CORD/T1-T6	72
95212	ANTERIOR CORD SYND/T1-T6	72
95213	CENTRAL CORD SYND/T1-T6	72
95214	T1-T6 SPIN CORD INJ NEC	72
95215	T7-T12 SPIN CORD INJ NOS	72
95216	COMPLETE LES CORD/T7-T12	72
95217	ANTERIOR CORD SYN/T7-T12	72
95218	CENTRAL CORD SYN/T7-T12	72
95219	T7-T12 SPIN CORD INJ NEC	72
9522	LUMBAR SPINAL CORD INJUR	72
9523	SACRAL SPINAL CORD INJUR	72
9524	CAUDA EQUINA INJURY	72
9528	SPIN CORD INJ-MULT SITE	72
9529	SPINAL CORD INJURY NOS	72
9530	CERVICAL ROOT INJURY	72
9531	DORSAL ROOT INJURY	72
9532	LUMBAR ROOT INJURY	72
9533	SACRAL ROOT INJURY	72
9534	BRACHIAL PLEXUS INJURY	72
9535	LUMBOSACRAL PLEX INJURY	72
9538	MULT NERVE ROOT/PLEX INJ	72
9539	INJ NERVE ROOT/PLEX NOS	72
9540	INJ CERV SYMPATH NERVE	72
9541	INJ SYMPATH NERVE NEC	72
9548	INJURY TRUNK NERVE NEC	72
9549	INJURY TRUNK NERVE NOS	72
9550	INJURY AXILLARY NERVE	72
9551	INJURY MEDIAN NERVE	72
9552	INJURY ULNAR NERVE	72
9553	INJURY RADIAL NERVE	72
9554	INJ MUSCULOCUTAN NERVE	72
9555	INJ CUTAN SENSO NERV/ARM	72
9556	INJURY DIGITAL NERVE	72
9557	INJ NERVE SHLDR/ARM NEC	72
9558	INJ MULT NERVE SHLDR/ARM	72
9559	INJ NERVE SHLDR/ARM NOS	72
9560	INJURY SCIATIC NERVE	72
9561	INJURY FEMORAL NERVE	72
9562	INJ POSTERIOR TIB NERVE	72
9563	INJURY PERONEAL NERVE	72
9564	INJ CUTAN SENSO NERV/LEG	72
9565	INJ NERVE PELV/LEG NEC	72
9568	INJ MULT NERVE PELV/LEG	72

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
9569	INJ NERVE PELV/LEG NOS	72
9570	INJ SUPERF NERV HEAD/NCK	72
9571	INJURY TO NERVE NEC	72
9578	INJURY TO MULT NERVES	72
9579	INJURY TO NERVE NOS	72
9580	AIR EMBOLISM	72
9581	FAT EMBOLISM	72
9582	SECONDARY/RECUR HEMORR	72
9583	POSTTRAUM WND INFEC NEC	97
9584	TRAUMATIC SHOCK	72
9585	TRAUMATIC ANURIA	72
9586	VOLKMANN'S ISCH CONTRACT	72
9587	TRAUM SUBCUTAN EMPHYSEMA	11
9588	EARLY COMPLIC TRAUMA NEC	11
9591	TRUNK INJURY NOS	11
9592	SHLDR/UPPER ARM INJ NOS	11
9593	ELB/FOREARM/WRST INJ NOS	11
9594	HAND INJURY NOS	11
9595	FINGER INJURY NOS	11
9596	HIP & THIGH INJURY NOS	11
9597	LOWER LEG INJURY NOS	11
9598	INJURY MLT SITE/SITE NEC	11
9599	INJURY-SITE NOS	11
9600	POISONING-PENICILLINS	72
9601	POIS-ANTIFUNGAL ANTIBIOT	72
9602	POISON-CHLORAMPHENICOL	72
9603	POIS-ERYTHROMYC/MACROLID	72
9604	POISONING-TETRACYCLINE	72
9605	POIS-CEPHALOSPORIN GROUP	72
9606	POIS-ANTIMYCOBAC ANTIBIO	72
9607	POIS-ANTINEOP ANTIBIOTIC	72
9608	POISONING-ANTIBIOTIC NEC	72
9609	POISONING-ANTIBIOTIC NOS	72
9610	POISONING-SULFONAMIDES	72
9611	POIS-ARSENIC ANTI-INFEC	72
9612	POIS-HEAV MET ANTI-INFEC	72
9613	POIS-QUINOLINE/HYDROXYQU	72
9614	POISONING-ANTIMALARIALS	72
9615	POIS-ANTIPROTOZ DRUG NEC	72
9616	POISONING-ANTHELMINTICS	72
9617	POISONING-ANTIVIRAL DRUG	72
9618	POIS-ANTIMYCOBAC DRG NEC	72
9619	POIS-ANTI-INFECT NEC/NOS	72
9620	POIS-CORTICOSTEROIDS	72
9621	POISONING-ANDROGENS	72
9622	POISONING-OVARIAN HORMON	72
9623	POISON-INSULIN/ANTIDIAB	72
9624	POIS-ANT PITUITARY HORM	72
9625	POIS-POST PITUITARY HORM	72
9626	POISONING-PARATHYROIDS	72
9627	POISONING-THYROID/DERIV	72
9628	POISON-ANTITHYROID AGENT	72
9629	POISONING HORMON NEC/NOS	72
9630	POIS-ANTIALLRG/ANTIEMET	72
9631	POIS-ANTINEOPL/IMMUNOSUP	72
9632	POISONING-ACIDIFYING AGT	72
9633	POISONING-ALKALIZING AGT	72
9634	POISONING-ENZYMES NEC	72
9635	POISONING-VITAMINS NEC	72
9638	POISONING-SYSTEM AGT NEC	72
9639	POISONING-SYSTEM AGT NOS	72
9640	POISONING-IRON/COMPOUNDS	72
9641	POISON-LIVER/ANTIANEMICS	72
9642	POISONING-ANTICOAGULANTS	72
9643	POISONING-VITAMIN K	72
9644	POISON-FIBRINOLYSIS AGNT	72
9645	POISONING-COAGULANTS	72
9646	POISONING-GAMMA GLOBULIN	72
9647	POISONING-BLOOD PRODUCT	72
9648	POISONING-BLOOD AGT NEC	72
9649	POISONING-BLOOD AGT NOS	72
96500	POISONING-OPIUM NOS	72
96501	POISONING-HEROIN	72
96502	POISONING-METHADONE	72
96509	POISONING-OPIATES NEC	72
9651	POISONING-SALICYLATES	72

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
9654	POIS-AROM ANALGESICS NEC	72
9655	POISONING-PYRAZOLE DERIV	72
9656	POISONING-ANTIRHEUMATICS	72
9657	POIS-NO-NARC ANALGES NEC	72
9658	POIS-ANALGES/ANTIPYR NEC	72
9659	POIS-ANALGES/ANTIPYR NOS	72
9660	POISON-OXAZOLIDINE DERIV	72
9661	POISON-HYDANTOIN DERIVAT	72
9662	POISONING-SUCCINIMIDES	72
9663	POIS-ANTICONVUL NEC/NOS	72
9664	POIS-ANTI-PARKINSON DRUG	72
9670	POISONING-BARBITURATES	72
9671	POISONING-CHLORAL HYDRAT	72
9672	POISONING-PARALDEHYDE	72
9673	POISONING-BROMINE COMPND	72
9674	POISONING-METHAQUALONE	72
9675	POISONING-GLUTETHIMIDE	72
9676	POISON-MIX SEDATIVE NEC	72
9678	POIS-SEDATIVE/HYPNOT NEC	72
9679	POIS-SEDATIVE/HYPNOT NOS	72
9680	POIS-CNS MUSCLE DEPRESS	72
9681	POISONING-HALOTHANE	72
9682	POISON-GAS ANESTHET NEC	72
9683	POISON-INTRAVEN ANESTHET	72
9684	POIS-GEN ANESTH NEC/NOS	72
9685	POIS-TOPIC/INFILT ANESTH	72
9686	POIS-NERVE/PLEX-BLK ANES	72
9687	POISON-SPINAL ANESTHETIC	72
9689	POIS-LOCAL ANEST NEC/NOS	72
9690	POISONING-ANTIDEPRESSANT	72
9691	POIS-PHENOTHIAZINE TRANQ	72
9692	POIS-BUTYROPHENONE TRANQ	72
9693	POISON-ANTIPSYCHOTIC NEC	72
9694	POIS-BENZODIAZEPINE TRAN	72
9695	POISON-TRANQUILIZER NEC	72
9696	POISONING-HALLUCINOGENS	72
9697	POISON-PSYCHOSTIMULANTS	72
9698	POISON-PSYCHOTROPIC NEC	72
9699	POISON-PSYCHOTROPIC NOS	72
9700	POISONING-ANALEPTICS	72
9701	POISON-OPIATE ANTAGONIST	72
9708	POIS-CNS STIMULANTS NEC	72
9709	POIS-CNS STIMULANT NOS	72
9710	POIS-PARASYMPATHOMIMETIC	72
9711	POIS-PARASYMPATHOLYTICS	72
9712	POISON-SYMPATHOMIMETICS	72
9713	POISONING-SYMPATHOLYTICS	72
9719	POIS-AUTONOMIC AGENT NOS	72
9720	POIS-CARD RHYTHM REGULAT	72
9721	POISONING-CARDIOTONICS	72
9722	POISONING-ANTILIPEMICS	72
9723	POIS-GANGLION BLOCK AGT	72
9724	POIS-CORONARY VASODILAT	72
9725	POISON-VASODILATOR NEC	72
9726	POIS-ANTIHYPERTEN AGENT	72
9727	POISON-ANTIVARICOSE DRUG	72
9728	POISON-CAPILLARY ACT AGT	72
9729	POIS-CARDIOVASC AGT NEC	72
9730	POIS-ANTACID/ANTIGASTRIC	72
9731	POIS-IRRITANT CATHARTICS	72
9732	POIS-EMOLLIENT CATHARTIC	72
9733	POISONING-CATHARTIC NEC	72
9734	POISONING-DIGESTANTS	72
9735	POISONING-ANTIDIARRH AGT	72
9736	POISONING-EMETICS	72
9738	POISONING-GI AGENTS NEC	72
9739	POISONING-GI AGENT NOS	72
9740	POIS-MERCURIAL DIURETICS	72
9741	POIS-PURINE DIURETICS	72
9742	POIS-H2CO3 ANHYDRA INHIB	72
9743	POISONING-SALURETICS	72
9744	POISONING-DIURETICS NEC	72
9745	POIS-ELECTRO/CAL/WAT AGT	72
9746	POISON-MINERAL SALTS NEC	72
9747	POIS-URIC ACID METABOL	72
9750	POISONING-OXYTOCIC AGENT	72

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
9751	POIS-SMOOTH MUSCLE RELAX	72
9752	POIS-SKELET MUSCLE RELAX	72
9753	POISON-MUSCLE AGENT NEC	72
9754	POISONING-ANTITUSSIVES	72
9755	POISONING-EXPECTORANTS	72
9756	POIS-ANTI-COLD DRUGS	72
9757	POISONING-ANTIASTHMATICS	72
9758	POIS-RESPIR DRUG NEC/NOS	72
9760	POIS-LOCAL ANTI-INFECT	72
9761	POISONING-ANTIPRURITICS	72
9762	POIS-LOC ASTRING/DETERG	72
9763	POIS-EMOL/DEMUL/PROTECT	72
9764	POISON-HAIR/SCALP PREP	72
9765	POIS-EYE ANTI-INFEC/DRUG	72
9766	POISON-ENT PREPARATION	72
9767	POIS-TOPICAL DENTAL DRUG	72
9768	POIS-SKIN/MEMBR AGNT NEC	72
9769	POIS-SKIN/MEMBR AGNT NOS	72
9770	POISONING-DIETETICS	72
9771	POISON-LIPOTROPIC DRUGS	72
9772	POISONING-ANTIDOTES NEC	72
9773	POISON-ALCOHOL DETERRENT	72
9774	POIS-PHARMACEUT EXCIPIEN	72
9778	POISON-MEDICINAL AGT NEC	72
9779	POISON-MEDICINAL AGT NOS	72
9780	POISONING-BCG VACCINE	72
9781	POIS-TYPH/PARATYPH VACC	72
9782	POISONING-CHOLERA VACCIN	72
9783	POISONING-PLAGUE VACCINE	72
9784	POISONING-TETANUS VACCIN	72
9785	POIS-DIPHTHERIA VACCINE	72
9786	POIS-PERTUSSIS VACCINE	72
9788	POIS-BACT VACCIN NEC/NOS	72
9789	POIS-MIX BACTER VACCINES	72
9790	POISON-SMALLPOX VACCINE	72
9791	POISON-RABIES VACCINE	72
9792	POISON-TYPHUS VACCINE	72
9793	POIS-YELLOW FEVER VACCIN	72
9794	POISONING-MEASLES VACCIN	72
9795	POIS-POLIOMYELIT VACCINE	72
9796	POIS-VIRAL/RICK VACC NEC	72
9797	POISONING-MIXED VACCINE	72
9799	POIS-VACCINE/BIOLOG NEC	72
9800	TOXIC EFF ETHYL ALCOHOL	72
9801	TOXIC EFF METHYL ALCOHOL	72
9802	TOXIC EFF ISOPROPYL ALC	72
9803	TOXIC EFFECT FUSEL OIL	72
9808	TOXIC EFFECT ALCOHOL NEC	72
9809	TOXIC EFFECT ALCOHOL NOS	72
981	TOXIC EFF PETROLEUM PROD	72
9820	TOXIC EFFECT BENZENE	72
9821	TOXIC EFF CARBON TETRACH	72
9822	TOXIC EFF CARBON DISULFI	72
9823	TX EF CL-HYDCARB SLV NEC	72
9824	TOXIC EFFECT NITROGLYCOL	72
9828	TOXIC EFF NONPETROL SOLV	72
9830	TOX EFF CORROSIVE AROMAT	72
9831	TOXIC EFFECT ACIDS	72
9832	TOXIC EFF CAUSTIC ALKALI	72
9839	TOXIC EFFECT CAUSTIC NOS	72
9840	TX EFF INORG LEAD COMPND	72
9841	TOX EFF ORG LEAD COMPND	72
9848	TOX EFF LEAD COMPND NEC	72
9849	TOX EFF LEAD COMPND NOS	72
9850	TOXIC EFFECT MERCURY	72
9851	TOXIC EFFECT ARSENIC	72
9852	TOXIC EFFECT MANGANESE	72
9853	TOXIC EFFECT BERYLLIUM	72
9854	TOXIC EFFECT ANTIMONY	72
9855	TOXIC EFFECT CADMIUM	72
9856	TOXIC EFFECT CHROMIUM	72
9858	TOXIC EFFECT METALS NEC	72
9859	TOXIC EFFECT METAL NOS	72
986	TOX EFF CARBON MONOXIDE	72
9870	TOXIC EFF LIQ PETROL GAS	72
9871	TOX EF HYDROCARB GAS NEC	72

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
9872	TOXIC EFF NITROGEN OXIDE	72
9873	TOXIC EFF SULFUR DIOXIDE	72
9874	TOXIC EFFECT FREON	72
9875	TOX EFF LACRIMOGENIC GAS	72
9876	TOXIC EFF CHLORINE GAS	72
9877	TOX EFF HYDROCYAN ACD GS	72
9878	TOXIC EFF GAS/VAPOR NEC	72
9879	TOXIC EFF GAS/VAPOR NOS	72
9880	TOXIC EFF FISH/SHELLFISH	72
9881	TOXIC EFFECT MUSHROOMS	72
9882	TOX EFF BERRY/PLANT NEC	72
9888	TOX EFF NOXIOUS FOOD NEC	72
9889	TOX EFF NOXIOUS FOOD NOS	72
9890	TOXIC EFFECT CYANIDES	72
9891	TOXIC EFFECT STRYCHNINE	72
9892	TOX EFF CHLOR HYDROCARB	72
9893	TOX EFF ORGANPHOS/CARBAM	72
9894	TOXIC EFF PESTICIDES NEC	72
9895	TOXIC EFFECT VENOM	72
9896	TOXIC EFF SOAP/DETERGENT	72
9897	TOX EFF AFLATOX/MYCOTOX	72
98981	TOXIC EFFECT OF ASBESTOS	72
98982	TOXIC EFFECT OF LATEX	72
98983	TOXIC EFFECT OF SILICONE	72
98984	TOXIC EFFECT OF TOBACCO	72
98989	TOX EFF NONMED SUBST NEC	72
9899	TOX EFF NONMED SUBST NOS	72
990	EFFECTS RADIATION NOS	72
9910	FROSTBITE OF FACE	72
9911	FROSTBITE OF HAND	72
9912	FROSTBITE OF FOOT	72
9913	FROSTBITE NEC/NOS	72
9914	IMMERSION FOOT	72
9915	CHILBLAINS	72
9916	HYPOTHERMIA	72
9918	EFFECT REDUCED TEMP NEC	72
9919	EFFECT REDUCED TEMP NOS	72
9920	HEAT STROKE & SUNSTROKE	72
9921	HEAT SYNCOPE	72
9922	HEAT CRAMPS	72
9923	HEAT EXHAUST-ANHYDROTIC	72
9924	HEAT EXHAUST-SALT DEPLE	72
9925	HEAT EXHAUSTION NOS	72
9926	HEAT FATIGUE, TRANSIENT	72
9927	HEAT EDEMA	72
9928	HEAT EFFECT NEC	72
9929	HEAT EFFECT NOS	72
9930	BAROTRAUMA, OTITIC	31
9931	BAROTRAUMA, SINUS	31
9932	EFF HIGH ALTITUD NEC/NOS	72
9933	CAISSON DISEASE	72
9934	EFF AIR PRESS BY EXPLOS	72
9938	EFFECT AIR PRESSURE NEC	72
9939	EFFECT AIR PRESSURE NOS	72
9940	EFFECTS OF LIGHTNING	72
9941	DROWNING/NONFATAL SUBMER	72
9942	EFFECTS OF HUNGER	72
9943	EFFECTS OF THIRST	72
9944	EXHAUSTION-EXPOSURE	72
9945	EXHAUSTION-EXCESS EXERT	72
9946	MOTION SICKNESS	11
9947	ASPHYXIATION/STRANGULAT	72
9948	EFFECTS ELECTRIC CURRENT	72
9949	EFFECT EXTERNAL CAUS NEC	72
9950	ANAPHYLACTIC SHOCK	78
9951	ANGIONEUROTIC EDEMA	72
9952	ADV EFF MED/BIOL SUB NOS	72
9953	ALLERGY, UNSPECIFIED	18
9954	SHOCK DUE TO ANESTHESIA	72
99560	ANPHYLCT SHK FOOD NOS	78
99561	ANPHYLCT SHK PEANUTS	78
99562	ANPHYLCT SHK CRSTACNS	78
99563	ANPHYLCT SHK FRTS VEG	78
99564	ANPHYLCT SHK TR NTS SEED	78
99565	ANPHYLCT SHK FISH	78
99566	ANPHYLCT SHK FOOD ADDTV	78

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
99567	ANPHYLCT SHK MILK PROD	78
99568	ANPHYLCT SHK EGGS	78
99569	ANPHYLCT SHK OT SPF FOOD	78
99581	ADULT PHYSICAL ABUSE	91
99589	ADVERSE EFFECT NEC	63
99600	MALFUNC CARD DEV/GRF NOS	36
99601	MALFUNC CARDIAC PACEMAKE	36
99602	MALFUNC PROSTH HRT VALVE	36
99603	MALFUNC CORON BYPASS GRF	36
99604	MCH CMP AUTM MPLNT DFBRL	36
99609	MALFUNC CARD DEV/GRF NEC	36
9961	MALFUNC VASC DEVICE/GRAF	36
9962	MALFUN NEURO DEVICE/GRAF	63
99630	MALFUNC GU DEV/GRAFT NOS	53
99631	MALFUNC URETHRAL CATH	53
99632	MALFUNCTION IUD	56
99639	MALFUNC GU DEV/GRAFT NEC	53
9964	MALF INT ORTHPED DEV/GRF	24
99651	CORNEAL GRFT MALFUNCTION	68
99652	OTH TISSUE GRAFT MALFUNC	72
99653	LENS PROSTHESIS MALFUNC	68
99654	BREAST PROSTH MALFUNC	18
99659	MALFUNC OTH DEVICE/GRAFT	72
99660	REACTION-UNSP DEVIC/GRFT	72
99661	REACT-CARDIAC DEV/GRAFT	36
99662	REACT-OTH VASC DEV/GRAFT	36
99663	REACT-NERV SYS DEV/GRAFT	63
99664	REACT-INDWELL URIN CATH	53
99665	REACT-OTH GENITOURIN DEV	53
99666	REACT-INTER JOINT PROST	24
99667	REACT-OTH INT ORTHO DEV	24
99669	REACT-INT PROS DEVIC NEC	72
99670	COMP-UNSP DEVICE/GRAFT	72
99671	COMP-HEART VALVE PROSTH	36
99672	COMP-OTH CARDIAC DEVICE	36
99673	COMP-REN DIALYS DEV/GRFT	36
99674	COMP-OTH VASC DEV/GRAFT	36
99675	COMP-NERV SYS DEV/GRAFT	63
99676	COMP-GENITOURIN DEV/GRFT	53
99677	COMP-INTERNAL JOINT PROS	24
99678	COMP-OTH INT ORTHO DEVIC	24
99679	COMP-INT PROST DEVIC NEC	72
99680	COMP ORGAN TRANSPLNT NOS	72
99681	COMPL KIDNEY TRANSPLANT	53
99682	COMPL LIVER TRANSPLANT	41
99683	COMPL HEART TRANSPLANT	36
99684	COMPL LUNG TRANSPLANT	33
99685	COMPL MARROW TRANSPLANT	86
99686	COMPL PANCREAS TRANSPLNT	41
99689	COMP OTH ORGAN TRANSPLNT	72
99690	COMP REATTACH EXTREM NOS	24
99691	COMPL REATTACHED FOREARM	24
99692	COMPL REATTACHED HAND	24
99693	COMPL REATTACHED FINGER	24
99694	COMPL REATTACHED ARM NEC	24
99695	COMPL REATTACHED FOOT	24
99696	COMPL REATTACHED LEG NEC	24
99699	COMPL REATTACH PART NEC	24
99700	NERVOUS SYST COMPLC NOS	63
99701	SURG COMPLICATION - CNS	63
99702	IATROGEN CV INFARC/HMRHG	63
99709	SURG COMP NERV SYSTM NEC	63
9971	SURG COMPL-HEART	36
9972	SURG COMP-PERI VASC SYST	36
9973	SURG COMPLIC-RESPIR SYST	33
9974	SURG COMP-DIGESTV SYSTEM	41
9975	SURG COMPL-URINARY TRACT	53
99760	AMPUTAT STUMP COMPL NOS	24
99761	NEUROMA AMPUTATION STUMP	24
99762	INFECTION AMPUTAT STUMP	24
99769	AMPUTAT STUMP COMPL NEC	24
99791	SURG COMP - HYPERTENSION	36
99799	SURG COMPL-BODY SYST NEC	11
9980	POSTOPERATIVE SHOCK	72
9982	ACCIDENTAL OP LACERATION	72
9983	POSTOP WOUND DISRUPTION	11

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
9984	FB LEFT DURING PROCEDURE	72
9985	POSTOPERATIVE INFECTION*	97
9986	PERSIST POSTOP FISTULA	72
9987	POSTOP FORGN SUBST REACT	72
99881	EMPHYSEMA RSULT FRM PROC	33
99882	CTRCT FRGMT FRM CTR SURG	68
99889	OTH SPCF CMPLC PROCD NEC	11
9989	SURGICAL COMPLICAT NOS	11
9990	GENERALIZED VACCINIA	97
9991	AIR EMBOL COMP MED CARE	33
9992	VASC COMP MED CARE NEC	36
9993	INFEC COMPL MED CARE NEC	97
9994	ANAPHYLACTIC SHOCK-SERUM	78
9995	SERUM REACTION NEC	86
9996	ABO INCOMPATIBILITY REAC	86
9997	RH INCOMPATIBILITY REACT	86
9998	TRANSFUSION REACTION NEC	86
9999	COMPLIC MED CARE NEC/NOS	11
*E8000	RR COLLISION NOS-EMPLOY	
*E8001	RR COLL NOS-PASSENGER	
*E8002	RR COLL NOS-PEDESTRIAN	
*E8003	RR COLL NOS-PED CYCLIST	
*E8008	RR COLL NOS-PERSON NEC	
*E8009	RR COLL NOS-PERSON NOS	
*E8010	RR COLL W OTH OBJ-EMPLOY	
*E8011	RR COLL W OTH OBJ-PASNGR	
*E8012	RR COLL W OTH OBJ-PEDEST	
*E8013	RR COLL W OTH OBJ-CYCL	
*E8018	RR COL W OTH OBJ-PER NEC	
*E8019	RR COL W OTH OBJ-PER NOS	
*E8020	RR ACC W DERAIL-EMPLOYEE	
*E8021	RR ACC W DERAIL-PASSENG	
*E8022	RR ACC W DERAIL-PEDEST	
*E8023	RR ACC W DERAIL-PED CYCL	
*E8028	RR ACC W DERAIL-PERS NEC	
*E8029	RR ACC W DERAIL-PERS NOS	
*E8030	RR ACC W EXPLOSION-EMPL	
*E8031	RR ACC W EXPLOS-PASNGR	
*E8032	RR ACC W EXPLOS-PEDEST	
*E8033	RR ACC W EXPLOS-PED CYCL	
*E8038	RR ACC W EXPLOS-PERS NEC	
*E8039	RR ACC W EXPLOS-PERS NOS	
*E8040	FALL ON/FROM TRAIN-EMPL	
*E8041	FALL FROM TRAIN-PASSENGR	
*E8042	FALL FROM TRAIN-PEDEST	
*E8043	FALL FROM TRAIN-PED CYCL	
*E8048	FALL FROM TRAIN-PERS NEC	
*E8049	FALL FROM TRAIN-PERS NOS	
*E8050	HIT BY TRAIN-EMPLOYEE	
*E8051	HIT BY TRAIN-PASSENGER	
*E8052	HIT BY TRAIN-PEDESTRIAN	
*E8053	HIT BY TRAIN-PED CYCLIST	
*E8058	HIT BY TRAIN-PERSON NEC	
*E8059	HIT BY TRAIN-PERSON NOS	
*E8060	RR ACC NEC-EMPLOYEE	
*E8061	RR ACC NEC-PASSENGER	
*E8062	RR ACC NEC-PEDESTRIAN	
*E8063	RR ACC NEC-PED CYCLIST	
*E8068	RR ACC NEC-PERSON NEC	
*E8069	RR ACC NEC-PERSON NOS	
*E8070	RR ACCIDENT NOS-EMPLOYEE	
*E8071	RR ACC NOS-PASSENGER	
*E8072	RR ACC NOS-PEDESTRIAN	
*E8073	RR ACC NOS-PED CYCLIST	
*E8078	RR ACC NOS-PERSON NEC	
*E8079	RR ACC NOS-PERSON NOS	
*E8100	MV-TRAIN COLL-DRIVER	
*E8101	MV-TRAIN COLL-PASNGR	
*E8102	MV-TRAIN COLL-MOTORCYCL	
*E8103	MV-TRAIN COLL-MCYCL PSGR	
*E8104	MV-TRAIN COLL-ST CAR	
*E8105	MV-TRAIN COLL-ANIM RID	
*E8106	MV-TRAIN COLL-PED CYCL	
*E8107	MV-TRAIN COLL-PEDEST	
*E8108	MV-TRAIN COLL-PERS NEC	
*E8109	MV-TRAIN COLL-PERS NOS	

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
*E8110	REENTRANT MV COLL-DRIVER	
*E8111	REENTRANT MV COLL-PASNGR	
*E8112	REENTRANT COLL-MOTCYCL	
*E8113	REENTRANT COLL-MCYC PSGR	
*E8114	REENTRANT COLL-ST CAR	
*E8115	REENTRANT COLL-ANIM RID	
*E8116	REENTRANT COLL-PED CYCL	
*E8117	REENTRANT COLL-PEDEST	
*E8118	REENTRANT COLL-PERS NEC	
*E8119	REENTRANT COLL-PERS NOS	
*E8120	MV COLLISION NOS-DRIVER	
*E8121	MV COLLISION NOS-PASNGR	
*E8122	MV COLLIS NOS-MOTORCYCL	
*E8123	MV COLL NOS-MCYCL PSNGR	
*E8124	MV COLLISION NOS-ST CAR	
*E8125	MV COLL NOS-ANIM RID	
*E8126	MV COLL NOS-PED CYCL	
*E8127	MV COLLISION NOS-PEDEST	
*E8128	MV COLLIS NOS-PERS NEC	
*E8129	MV COLLIS NOS-PERS NOS	
*E8130	MV-OTH VEH COLL-DRIVER	
*E8131	MV-OTH VEH COLL-PASNGR	
*E8132	MV-OTH VEH COLL-MOTCYCL	
*E8133	MV-OTH VEH COLL-MCYC PSG	
*E8134	MV-OTH VEH COLL-ST CAR	
*E8135	MV-OTH VEH COLL-ANIM RID	
*E8136	MV-OTH VEH COLL-PED CYCL	
*E8137	MV-OTH VEH COLL-PEDEST	
*E8138	MV-OTH VEH COLL-PERS NEC	
*E8139	MV-OTH VEH COLL-PERS NOS	
*E8140	MV COLL W PEDEST-DRIVER	
*E8141	MV COLL W PEDEST-PASNGR	
*E8142	MV COLL W PEDEST-MOTCYCL	
*E8143	MV COLL W PED-MCYCL PSGR	
*E8144	MV COLL W PEDEST-ST CAR	
*E8145	MV COLL W PED-ANIM RID	
*E8146	MV COLL W PED-PED CYCL	
*E8147	MV COLL W PEDEST-PEDEST	
*E8148	MV COLL W PEDES-PERS NEC	
*E8149	MV COLL W PEDES-PERS NOS	
*E8150	MV COLL W OTH OBJ-DRIVER	
*E8151	MV COLL W OTH OBJ-PASNGR	
*E8152	MV COLL W OTH OBJ-MOCYCL	
*E8153	MV COLL W OBJ-MCYCL PSGR	
*E8154	MV COLL W OBJ-ST CAR	
*E8155	MV COLL W OBJ-ANIM RIDER	
*E8156	MV COLL W OBJ-PED CYCL	
*E8157	MV COLL W OBJ-PEDEST	
*E8158	MV COLL W OBJ-PERS NEC	
*E8159	MV COLL W OBJ-PERS NOS	
*E8160	LOSS CONTROL MV ACC-DRIV	
*E8161	LOSS CONTROL MV ACC-PSGR	
*E8162	LOSS CONTROL MV-MOCYCL	
*E8163	LOSS CONTROL MV-MCYC PSG	
*E8164	LOSS CONT MV ACC-ST CAR	
*E8165	LOSS CONT MV-ANIM RIDER	
*E8166	LOSS CONTROL MV-PED CYCL	
*E8167	LOSS CONTROL MV-PEDEST	
*E8168	LOSS CONTROL MV-PERS NEC	
*E8169	LOSS CONTROL MV-PERS NOS	
*E8170	MV ACC BOARD/ALIGHT-DRIV	
*E8171	MV ACC BOARD/ALIGHT-PSGR	
*E8172	MV BOARD/ALIGHT-MOTCYCL	
*E8173	MV BRD/ALIGHT-MCYCL PSGR	
*E8174	MV ACC BRD/ALIGHT-ST CAR	
*E8175	MV BRD/ALIGHT-ANIM RIDER	
*E8176	MV BRD/ALIGHT-PED CYCL	
*E8177	MV BRD/ALIGHT-PEDESTRIAN	
*E8178	MV BOARD/ALIGHT-PERS NEC	
*E8179	MV BOARD/ALIGHT-PERS NOS	
*E8180	MV TRAFF ACC NEC-DRIVER	
*E8181	MV TRAFF ACC NEC-PASNGR	
*E8182	MV TRAFF ACC NEC-MOCYCL	
*E8183	MV TRAFF ACC-MCYCL PSGR	
*E8184	MV TRAFF ACC NEC-ST CAR	
*E8185	MV TRAFF ACC-ANIM RIDER	

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
*E8186	MV TRAFF ACC-PED CYC	
*E8187	MV TRAFF ACC NEC-PEDEST	
*E8188	MV TRAFF ACC-PERS NEC	
*E8189	MV TRAFF ACC-PERS NOS	
*E8190	TRAFFIC ACC NOS-DRIVER	
*E8191	TRAFFIC ACC NOS-PASNGR	
*E8192	TRAFFIC ACC NOS-MOTCYCL	
*E8193	TRAFF ACC NOS-MCYCL PSGR	
*E8194	TRAFFIC ACC NOS-ST CAR	
*E8195	TRAFF ACC NOS-ANIM RIDER	
*E8196	TRAFFIC ACC NOS-PED CYCL	
*E8197	TRAFFIC ACC NOS-PEDEST	
*E8198	TRAFFIC ACC NOS-PERS NEC	
*E8199	TRAFFIC ACC NOS-PERS NOS	
*E8200	SNOW VEH ACC-DRIVER	
*E8201	SNOW VEH ACC-PASNGR	
*E8202	SNOW VEH ACC-MOTORCYCL	
*E8203	SNOW VEH ACC-MCYCL PSGR	
*E8204	SNOW VEH ACC-ST CAR	
*E8205	SNOW VEH ACC-ANIM RIDER	
*E8206	SNOW VEH ACC-PED CYCL	
*E8207	SNOW VEH ACC-PEDEST	
*E8208	SNOW VEH ACC-PERS NEC	
*E8209	SNOW VEH ACC-PERS NOS	
*E8210	OTH OFF-ROAD MV ACC-DRIV	
*E8211	OTH OFF-ROAD MV ACC-PSGR	
*E8212	OTH OFF-ROAD MV-MOCYCL	
*E8213	OTH OFF-ROAD MV-MCYC PSG	
*E8214	OTH OFF-ROAD MV-ST CAR	
*E8215	OTH OFF-ROAD MV-ANIM RID	
*E8216	OTH OFF-ROAD MV-PED CYCL	
*E8217	OTH OFF-ROAD MV-PEDEST	
*E8218	OTH OFF-ROAD MV-PERS NEC	
*E8219	OTH OFF-ROAD MV-PERS NOS	
*E8220	OTH COLL W MOV OBJ-DRIV	
*E8221	OTH COLL W MOV OBJ-PSGR	
*E8222	OTH COLL MOV OBJ-MOCYCL	
*E8223	OTH COLL MOV OBJ-CYC PSG	
*E8224	OTH COLL MOV OBJ-ST CAR	
*E8225	OTH COLL MOV OBJ-RIDER	
*E8226	OTH COLL MOV OBJ-PED CYC	
*E8227	OTH COLL MOV OBJ-PEDEST	
*E8228	OTH COLL MOV OBJ-PER NEC	
*E8229	OTH COLL MOV OBJ-PER NOS	
*E8230	OTH COLL STNDNG OBJ-DRIV	
*E8231	OTH COLL STNDNG OBJ-PSGR	
*E8232	OTH COLL STND OBJ-MOCYCL	
*E8233	OTH COLL STN OBJ-CYC PSG	
*E8234	OTH COLL STND OBJ-ST CAR	
*E8235	OTH COLL STND OBJ-RIDER	
*E8236	OTH COLL STN OBJ-PED CYC	
*E8237	OTH COLL STND OBJ-PEDEST	
*E8238	OTH COLL STN OBJ-PER NEC	
*E8239	OTH COL-STND-OBJ-PER NOS	
*E8240	N-TRAF BOARD/ALIGHT-DRIV	
*E8241	N-TRAF BOARD/ALIGHT-PSGR	
*E8242	N-TRAF BRD/ALIGHT-MOCYCL	
*E8243	N-TRAF BRD/ALIT-MCYC PSG	
*E8244	N-TRAF BRD/ALIT-ST CAR	
*E8245	N-TRAF BRD/ALIT-ANIM RID	
*E8246	N-TRAF BRD/ALIT-PED CYCL	
*E8247	N-TRAF BRD/ALIT-PEDEST	
*E8248	N-TRAF BRD/ALIT-PERS NEC	
*E8249	N-TRAF BRD/ALIT-PERS NOS	
*E8250	MV N-TRAFF ACC NEC-DRIV	
*E8251	MV N-TRAFF NEC/NOS-PSGR	
*E8252	MV N-TRAF ACC NEC-MOCYCL	
*E8253	MV N-TRAFF NEC-MCYC PSGR	
*E8254	MV N-TRAFF NEC-ST CAR	
*E8255	MV N-TRAF NEC-ANIM RIDER	
*E8256	MV N-TRAFF NEC-PED CYCL	
*E8257	MV N-TRAFF NEC-PEDEST	
*E8258	MV N-TRAFF NEC-PERS NEC	
*E8259	MV N-TRAFF NEC-PERS NOS	
*E8260	PEDAL CYCLE ACC-PEDEST	
*E8261	PED CYCL ACC-PED CYCLIST	

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
*E8262	PED CYCLE ACC-ANIM RIDER	
*E8263	PED CYC ACC-OCC ANIM VEH	
*E8264	PED CYCLE ACC-OCC ST CAR	
*E8268	PED CYCLE ACC-PERS NEC	
*E8269	PED CYCLE ACC-PERS NOS	
*E8270	ANIMAL DRAWN VEH-PEDEST	
*E8272	ANIM DRAWN VEH-ANIM RID	
*E8273	ANIMAL DRAWN VEH-OCCUPAN	
*E8274	ANIM DRAWN-OCC ST CAR	
*E8278	ANIM DRAWN VEH-PERS NEC	
*E8279	ANIM DRAWN VEH-PERS NOS	
*E8280	RIDDEN ANIMAL ACC-PEDEST	
*E8282	RIDDEN ANIMAL ACC-RIDER	
*E8284	RIDDEN ANIMAL ACC-ST CAR	
*E8288	RIDDEN ANIM ACC-PERS NEC	
*E8289	RIDDEN ANIM ACC-PERS NOS	
*E8290	OTH ROAD VEH ACC-PEDEST	
*E8294	OTH RD VEH ACC-ST CAR	
*E8298	OTH RD VEH ACC-PERS NEC	
*E8299	OTH RD VEH ACC-PERS NOS	
*E8300	BOAT ACC W SUBMERS-UNPOW	
*E8301	BOAT ACC W SUBMERS-POWER	
*E8302	BOAT ACC W SUBMERS-CREW	
*E8303	BOAT ACC W SUBMERS-PSGR	
*E8304	BOAT SUBMERS-WATER SKIER	
*E8305	BOAT SUBMERS-SWIMMER	
*E8306	BOAT SUBMERS-DOCKERS	
*E8308	BOAT SUBMERS-PERS NEC	
*E8309	BOAT SUBMERS-PERS NOS	
*E8310	BOAT ACC INJ NEC-UNPOWER	
*E8311	BOAT ACC INJ NEC-POWER	
*E8312	BOAT ACC INJ NEC-CREW	
*E8313	BOAT ACC INJ NEC-PASSENG	
*E8314	BOAT ACC INJ NEC-SKIER	
*E8315	BOAT ACC INJ NEC-SWIM	
*E8316	BOAT ACC INJ NEC-DOCKER	
*E8318	BOAT INJ NEC-PERSON NEC	
*E8319	BOAT INJ NEC-PERSON NOS	
*E8320	SUBMERS NEC-UNPOW BOAT	
*E8321	SUBMERS NEC-POWER BOAT	
*E8322	SUBMERS NEC-CREW	
*E8323	SUBMERS NEC-PASSENGER	
*E8324	SUBMERS NEC-WATER SKIER	
*E8325	SUBMERS NEC-SWIMMER	
*E8326	SUBMERS NEC-DOCKER	
*E8328	SUBMERS NEC-PERSON NEC	
*E8329	SUBMERS NEC-PERSON NOS	
*E8330	W/CRAFT STAIR FALL-UNPOW	
*E8331	W/CRAFT STAIR FALL-POWER	
*E8332	WTRCRAFT STAIR FALL-CREW	
*E8333	WTRCRAFT STAIR FALL-PSGR	
*E8334	W/CRAFT STAIR FALL-SKIER	
*E8335	W/CRAFT STAIR FALL-SWIM	
*E8336	W/CRF STAIR FALL-DOCKER	
*E8338	W/CRF STAIR FALL-PER NEC	
*E8339	W/CRF STAIR FALL-PER NOS	
*E8340	W/CRAFT FALL NEC-UNPOW	
*E8341	W/CRAFT FALL NEC-POWER	
*E8342	WATERCRAFT FALL NEC-CREW	
*E8343	WTRCRAFT FALL NEC-PASNGR	
*E8344	W/CRAFT FALL NEC-SKIER	
*E8345	W/CRAFT FALL NEC-SWIM	
*E8346	WTRCRAFT FALL NEC-DOCKER	
*E8348	W/CRFT FALL NEC-PERS NEC	
*E8349	W/CRFT FALL NEC-PERS NOS	
*E8350	W/CRAFT FALL NOS-UNPOW	
*E8351	W/CRAFT FALL NOS-POWER	
*E8352	WTRCRAFT FALL NOS-CREW	
*E8353	WTRCRAFT FALL NOS-PASNGR	
*E8354	W/CRAFT FALL NOS-SKIER	
*E8355	W/CRAFT FALL NOS-SWIM	
*E8356	WTRCRAFT FALL NOS-DOCKER	
*E8358	W/CRFT FALL NOS-PERS NEC	
*E8359	W/CRFT FALL NOS-PERS NOS	
*E8360	MACHINE ACC-UNPOW BOAT	
*E8361	MACH ACC-OCC POWER BOAT	

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
*E8362	MACHINERY ACCIDENT-CREW	
*E8363	MACHINERY ACC-PASNGR	
*E8364	MACHINE ACCIDENT-SKIER	
*E8365	MACHINE ACCIDENT-SWIM	
*E8366	MACHINERY ACC-DOCKER	
*E8368	MACHINERY ACC-PERS NEC	
*E8369	MACHINERY ACC-PERS NOS	
*E8370	EXPLOSION-OCC UNPOW BOAT	
*E8371	EXPLOSION-OCC POWER BOAT	
*E8372	WATERCRAFT EXPLOS-CREW	
*E8373	WATERCRAFT EXPLOS-PASNGR	
*E8374	WATERCRAFT EXPLOS-SKIER	
*E8375	WATERCRAFT EXPLOS-SWIM	
*E8376	WATERCRAFT EXPLOS-DOCKER	
*E8378	WATERCRAFT EXPL-PERS NEC	
*E8379	WATERCRAFT EXPL-PERS NOS	
*E8380	WATERCRAFT ACC NEC-UNPOW	
*E8381	WATERCRAFT ACC NEC-POWER	
*E8382	WATERCRAFT ACC NEC-CREW	
*E8383	WATERCRFT ACC NEC-PASNGR	
*E8384	WATERCRAFT ACC NEC-SKIER	
*E8385	WATRCRFT ACC NEC-SWIMMER	
*E8386	WATERCRFT ACC NEC-DOCKER	
*E8388	WTRCRFT ACC NEC-PERS NEC	
*E8389	WTRCRFT ACC NEC-PERS NOS	
*E8400	TK OFF/LAND-SPCRFT	
*E8401	TK OFF/LAND-MILIT CRAFT	
*E8402	TK OFF/LAND-CREW AIRCRFT	
*E8403	TK OFF/LAND-PSNG AIRCRFT	
*E8404	TK OFF/LAND-COMM CRF NEC	
*E8405	TK OFF/LAND-AIRCRAFT NEC	
*E8406	TK OFF/LAND-UNP AIRCRFT	
*E8407	TK OFF/LAND-PARACHUTIST	
*E8408	TK OFF/LAND-GROUND CREW	
*E8409	TK OFF/LAND-PERS NEC	
*E8410	POW AIRCRAFT ACC-SPCRFT	
*E8411	POWER AIRCRAFT ACC-MILIT	
*E8412	POWER AIRCRAFT ACC-CREW	
*E8413	POWER AIRCRAFT ACC-PSNGR	
*E8414	AIRCRAF ACC-OCC COMM NEC	
*E8415	OTH POWERED AIRCRAFT ACC	
*E8416	POW AIRC ACC-UNP AIRCR	
*E8417	AIRCRAFT ACC-PARACHUTIST	
*E8418	AIRCRAFT ACC-GROUND CREW	
*E8419	AIRCRFT ACC NOS-PERS NEC	
*E8426	UNPOWER AIRCRAFT ACC-OCC	
*E8427	UNPOW AIRCRF ACC-CHUTIST	
*E8428	UNPOW AIRCRF ACC-GR CREW	
*E8429	UNPOW AIRCRF ACC-PER NEC	
*E8430	FALL-OCC SPACECRAFT	
*E8431	FALL-MILIT AIRCRAFT OCCP	
*E8432	FALL-CREW COMM AIRCRAFT	
*E8433	FALL-PSNG COMM AIRCRAFT	
*E8434	FALL-OCC COMM AIRCRF NEC	
*E8435	FALL-OCCUP OTH AIRCRAFT	
*E8436	FALL-OCC UNPOWER AIRCRAF	
*E8437	FALL-PARACHUTIST	
*E8438	AIRCRFT FALL-GROUND CREW	
*E8439	AIRCRAFT FALL-PERSON NEC	
*E8440	AIRCRFT ACC NEC-SPCRFT	
*E8441	AIRCRFT ACC NEC-MILITARY	
*E8442	AIRCRFT ACC NEC-CREW	
*E8443	AIRCRFT ACC NEC-PASNGR	
*E8444	AIRCRFT ACC NEC-COMM NEC	
*E8445	AIRCRFT ACC NEC-OCCP NEC	
*E8446	AIRCR ACC NEC-UNP AIRCR	
*E8447	AIRCRFT ACC-PARACHUTIST	
*E8448	AIRCRFT ACC NEC-GRD CREW	
*E8449	AIRCRFT ACC NEC-PERS NEC	
*E8450	SPACECRAFT ACC-OCCUPANT	
*E8458	SPACECRAFT ACC-GRND CREW	
*E8459	SPACECRAFT ACC-PERS NEC	
*E846	INDUS VEH ACC ON PREMISE	
*E847	CABL CAR ACC NOT ON RAIL	
*E848	OTH VEHICLE ACC NEC	
*E8490	ACCIDENT IN HOME	

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
*E8491	ACCIDENT ON FARM	
*E8492	ACCIDENT IN MINE/QUARRY	
*E8493	ACC ON INDUSTR PREMISES	
*E8494	ACCID IN RECREATION AREA	
*E8495	ACCID ON STREET/HIGHWAY	
*E8496	ACCIDENT IN PUBLIC BLDG	
*E8497	ACCID IN RESIDENT INSTIT	
*E8498	ACCIDENT IN PLACE NEC	
*E8499	ACCIDENT IN PLACE NOS	
*E8500	ACC POISON-HEROIN	
*E8501	ACC POISON-METHADONE	
*E8502	ACC POISON-OPIATES NEC	
*E8503	ACC POISON-SALICYLATES	
*E8504	ACC POISON-AROM ANALGESC	
*E8505	ACC POISON-PYRAZOLE DERV	
*E8506	ACC POISON-ANTIRHEUMATIC	
*E8507	ACC POISON-NONNARC ANALG	
*E8508	ACC POISON-ANALGESIC NEC	
*E8509	ACC POISON-ANALGESIC NOS	
*E851	ACC POISON-BARBITURATES	
*E8520	ACC POISN-CHLORL HYDRATE	
*E8521	ACC POISON-PARALDEHYDE	
*E8522	ACC POISON-BROMINE CMPND	
*E8523	ACC POISON-METHAQUALONE	
*E8524	ACC POISON-GLUTETHIMIDE	
*E8525	ACC POISON-MIX SEDTV NEC	
*E8528	ACC POISON-SEDATIVES NEC	
*E8529	ACC POISON-SEDATIVES NOS	
*E8530	ACC POIS-PHENTHIAZ TRANQ	
*E8531	ACC POIS-BUTYRPHEN TRANQ	
*E8532	ACC POISN-BENZDIAZ TRANQ	
*E8538	ACC POISN-TRANQUILZR NEC	
*E8539	ACC POISN-TRANQUILZR NOS	
*E8540	ACC POISON-ANTIDEPRESSNT	
*E8541	ACC POISON-HALLUCINOGENS	
*E8542	ACC POISN-PSYCHSTIMULANT	
*E8543	ACC POISON-CNS STIMULANT	
*E8548	ACC POISN PSYCHOTROP NEC	
*E8550	ACC POISN-ANTICONVULSANT	
*E8551	ACC POISN-CNS DEPRES NEC	
*E8552	ACC POISN-LOCAL ANESTHET	
*E8553	ACC POISON-CHOLINERGICS	
*E8554	ACC POISN-ANTICHOLINERG	
*E8555	ACC POISON-ADRENERGICS	
*E8556	ACC POISN-SYMPATHOLYTICS	
*E8558	ACC POISON-CNS DRUG NEC	
*E8559	ACC POISON-CNS DRUG NOS	
*E856	ACC POISON-ANTIBIOTICS	
*E857	ACC POIS-OTH ANTI-INFECT	
*E8580	ACC POISON-HORMONES	
*E8581	ACC POISN-SYSTEMIC AGENT	
*E8582	ACC POISON-BLOOD AGENT	
*E8583	ACC POISN-CARDIOVASC AGT	
*E8584	ACC POISON-GI AGENT	
*E8585	ACC POISN-METABOL AGNT	
*E8586	ACC POISN-MUSCL/RESP AGT	
*E8587	ACC POISN-SKIN/EENT AGNT	
*E8588	ACC POISONING-DRUG NEC	
*E8589	ACC POISONING-DRUG NOS	
*E8600	ACC POISN-ALCOHOL BEVRAG	
*E8601	ACC POISON-ETHYL ALCOHOL	
*E8602	ACC POISN-METHYL ALCOHOL	
*E8603	ACC POISN-ISOPROPYL ALC	
*E8604	ACC POISON-FUSEL OIL	
*E8608	ACC POISON-ALCOHOL NEC	
*E8609	ACC POISON-ALCOHOL NOS	
*E8610	ACC POIS-SYNTH DETERGENT	
*E8611	ACC POISON-SOAP PRODUCTS	
*E8612	ACC POISON-POLISHES	
*E8613	ACC POISON-CLEANSER NEC	
*E8614	ACC POISON-DISINFECTANTS	
*E8615	ACC POISON-LEAD PAINTS	
*E8616	ACC POISON-PAINTS NEC	
*E8619	ACC POISON-CLEANSER NOS	
*E8620	ACC POISN-PETROL SOLVENT	
*E8621	ACC POISN-PETROLEUM FUEL	

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
*E8622	ACC POIS-LUBRICATING OIL	
*E8623	ACC POIS-PETROLEUM SOLID	
*E8624	ACC POISN-SOLVENTS NEC	
*E8629	ACC POISN-SOLVENT NOS	
*E8630	ACC POIS-CHLORINE PESTIC	
*E8631	ACC POIS-PHOSPH PESTICID	
*E8632	ACC POISON-CARBAMATES	
*E8633	ACC POISN-MIXED PESTICID	
*E8634	ACC POISON-PESTICIDE NEC	
*E8635	ACC POISON-HERBICIDES	
*E8636	ACC POISON-FUNGICIDES	
*E8637	ACC POISON-RODENTICIDES	
*E8638	ACC POISON-FUMIGANTS	
*E8639	ACC POIS-AGRCULT NEC/NOS	
*E8640	ACC POIS-CORROSIV AROMAT	
*E8641	ACC POISON-ACIDS	
*E8642	ACC POISN-CAUSTIC ALKALI	
*E8643	ACC POISON-CAUSTIC NEC	
*E8644	ACC POISON-CAUSTIC NOS	
*E8650	ACC POISON-MEAT	
*E8651	ACC POISON-SHELLFISH	
*E8652	ACC POISON-FISH NEC	
*E8653	ACC POISON-BERRIES/SEEDS	
*E8654	ACC POISON-PLANTS NEC	
*E8655	ACC POISON-MUSHROOMS	
*E8658	ACC POISON-FOOD NEC	
*E8659	ACC POISN-FOOD/PLANT NOS	
*E8660	ACC POISONING-LEAD	
*E8661	ACC POISONING-MERCURY	
*E8662	ACC POISONING-ANTIMONY	
*E8663	ACC POISONING-ARSENIC	
*E8664	ACC POISON-METALS NEC	
*E8665	ACC POISON-PLANT FOOD	
*E8666	ACC POISON-GLUES	
*E8667	ACC POISON-COSMETICS	
*E8668	ACC POIS-SOLID/LIQ NEC	
*E8669	ACC POIS-SOLID/LIQ NOS	
*E867	ACC POISON-PIPED GAS	
*E8680	ACC POIS-LIQ PETROL GAS	
*E8681	ACC POIS-UTL GAS NEC/NOS	
*E8682	ACC POISON-EXHAUST GAS	
*E8683	ACC POIS-CO/DOMESTC FUEL	
*E8688	ACC POIS-CARBN MONOX NEC	
*E8689	ACC POIS-CARBN MONOX NOS	
*E8690	ACC POISN-NITROGEN OXIDE	
*E8691	ACC POISN-SULFUR DIOXIDE	
*E8692	ACC POISON-FREON	
*E8693	ACC POISON-TEAR GAS	
*E8694	SCNDHND TBCCO SMOKE	
*E8698	ACC POISON-GAS/VAPOR NEC	
*E8699	ACC POISON-GAS/VAPOR NOS	
*E8700	ACC CUT/HEM IN SURGERY	
*E8701	ACC CUT/HEM IN INFUSION	
*E8702	ACC CUT/HEM-PERFUSN NEC	
*E8703	ACC CUT/HEM IN INJECTION	
*E8704	ACC CUT/HEM W SCOPE EXAM	
*E8705	ACC CUT/HEM W CATHETERIZ	
*E8706	ACC CUT/HEM W HEART CATH	
*E8707	ACC CUT/HEM W ENEMA	
*E8708	ACC CUT IN MED CARE NEC	
*E8709	ACC CUT IN MED CARE NOS	
*E8710	POST-SURGICAL FORGN BODY	
*E8711	POSTINFUSION FOREIGN BDY	
*E8712	POSTPERFUSION FORGN BODY	
*E8713	POSTINJECTION FORGN BODY	
*E8714	POSTENDOSCOPY FORGN BODY	
*E8715	POSTCATHETER FORGN BODY	
*E8716	FB POST HEART CATHETER	
*E8717	FB POST-CATHETER REMOVAL	
*E8718	POST-OP FOREIGN BODY NEC	
*E8719	POST-OP FOREIGN BODY NOS	
*E8720	FAILURE STERILE SURGERY	
*E8721	FAILURE STERILE INFUSION	
*E8722	FAIL STERILE PERFUSN NEC	
*E8723	FAIL STERILE INJECTION	
*E8724	FAIL STERILE ENDOSCOPY	

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
*E8725	FAIL STERILE CATHETER	
*E8726	FAIL STERILE HEART CATH	
*E8728	FAIL STERILE PROCED NEC	
*E8729	FAIL STERILE PROCED NOS	
*E8730	EXCESS FLUID IN INFUSION	
*E8731	INCOR DILUT INFUSN FLUID	
*E8732	THERAP RADIATION OVERDOS	
*E8733	INADV RADIAT EXP-MEDICAL	
*E8734	DOSAG FAIL-SHOCK THERAPY	
*E8735	WRNG TEMP IN APPLIC/PACK	
*E8736	NONADMIN NECESS MEDICINE	
*E8738	FAILURE IN DOSAGE NEC	
*E8739	FAILURE IN DOSAGE NOS	
*E8740	INSTRMNT FAIL IN SURGERY	
*E8741	INSTRUMNT FAIL-INFUSION	
*E8742	INSTRMNT FAIL-PERFUS NEC	
*E8743	INSTRUMNT FAIL-ENDOSCOPY	
*E8744	INSTRMNT FAIL-CATHETERIZ	
*E8745	INSTRMNT FAIL-HEART CATH	
*E8748	INSTRMNT FAIL-PROCED NEC	
*E8749	INSTRMNT FAIL-PROCED NOS	
*E8750	CONTAMINATED TRANSFUSION	
*E8751	CONTAMINATED INJECTION	
*E8752	CONTAMINATED DRUG NEC	
*E8758	CONTAMINATION NEC	
*E8759	CONTAMINATION NOS	
*E8760	MISMATCH BLOOD-TRANSFUSN	
*E8761	WRONG FLUID IN INFUSION	
*E8762	FAILURE IN SUTURE	
*E8763	MISPLACED ENDOTRACH TUBE	
*E8764	FAIL INTROD/REMOVE TUBE	
*E8765	PERFORMANCE-INAPPROP OP	
*E8768	MEDICAL MISADVENTURE NEC	
*E8769	MEDICAL MISADVENTURE NOS	
*E8780	ABN REACT-ORG TRANSPLANT	
*E8781	ABN REACT-ARTIF IMPLANT	
*E8782	ABN REACT-ANASTOM/GRAFT	
*E8783	ABN REACT-EXTERNAL STOMA	
*E8784	ABN REACT-PLAST SURG NEC	
*E8785	ABN REACT-LIMB AMPUTAT	
*E8786	ABN REAC-ORGAN REM NEC	
*E8788	ABN REACT-SURG PROC NEC	
*E8789	ABN REACT-SURG PROC NOS	
*E8790	ABN REACT-CARDIAC CATH	
*E8791	ABN REACT-RENAL DIALYSIS	
*E8792	ABN REACT-RADIOTHERAPY	
*E8793	ABN REACT-SHOCK THERAPY	
*E8794	ABN REACT-FLUID ASPIRAT	
*E8795	ABN REACT-GASTRIC SOUND	
*E8796	ABN REACT-URINARY CATH	
*E8797	ABN REACT-BLOOD SAMPLING	
*E8798	ABN REACT-PROCEDURE NEC	
*E8799	ABN REACT-PROCEDURE NOS	
*E8800	FALL ON ESCALATOR	
*E8801	FALL ON SIDEWALK CURB	
*E8809	FALL ON STAIR/STEP NEC	
*E8810	FALL FROM LADDER	
*E8811	FALL FROM SCAFFOLDING	
*E882	FALL FROM BUILDING	
*E8830	DIVING ACCIDENT	
*E8831	FALL INTO WELL	
*E8832	FALL INTO STORM DRAIN	
*E8839	FALL INTO OTHER HOLE	
*E8840	FALL FROM PLAYGRND EQUIP	
*E8841	FALL FROM CLIFF	
*E8842	FALL FROM CHAIR	
*E8843	FALL FROM WHEELCHAIR	
*E8844	FALL FROM BED	
*E8845	FALL FROM FURNITURE NEC	
*E8846	FALL FROM COMMODE	
*E8849	FALL-1 LEVEL TO OTH NEC	
*E885	FALL ON LEVEL-TRIPPING	
*E8860	FALL IN SPORTS	
*E8869	FALL ON LEVEL NEC/NOS	
*E887	FRACTURE, CAUSE NOS	
*E888	FALL NEC & NOS	

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
*E8900	PRIVAT DWELL FIRE-EXPLOS	
*E8901	PRIV DWEL FIRE-PVC FUMES	
*E8902	PRIV DWEL FIRE-FUMES NOS	
*E8903	PRIV DWEL FIRE-BURNING	
*E8908	PRIV DWEL FIRE-ACCID NEC	
*E8909	PRIV DWEL FIRE-ACCID NOS	
*E8910	FIRE IN BLDG-EXPLOSION	
*E8911	FIRE IN BLDG-PVC FUMES	
*E8912	FIRE IN BLDG-FUMES NOS	
*E8913	FIRE IN BLDG-BURNING	
*E8918	FIRE IN BLDG-ACCID NEC	
*E8919	FIRE IN BLDG-ACCID NOS	
*E892	FIRE NOT IN BUILDING	
*E8930	CLOTHING FIRE-PRIV DWELL	
*E8931	CLOTHING FIRE-BLDG NEC	
*E8932	CLOTHING FIRE NOT IN BLD	
*E8938	CLOTHING FIRE NEC	
*E8939	CLOTHING FIRE NOS	
*E894	FIRE-HIGHLY INFLAM MATER	
*E895	BURN ACC IN PRIVAT DWELL	
*E896	BURN ACC IN BLDG NEC	
*E897	BURN ACC NOT IN BLDG	
*E8980	BURNING BEDCLOTHES	
*E8981	FIRE ACCIDENT NEC	
*E899	FIRE ACCIDENT NOS	
*E9000	EXCESSIVE HEAT: WEATHER	
*E9001	EXCESSIVE HEAT, MAN-MADE	
*E9009	EXCESSIVE HEAT NOS	
*E9010	EXCESSIVE COLD: WEATHER	
*E9011	EXCESSIVE COLD, MAN-MADE	
*E9018	EXCESSIVE COLD NEC	
*E9019	EXCESSIVE COLD NOS	
*E9020	HIGH ALTITUDE RESIDENCE	
*E9021	AIR PRESS CHNGE: AIRCRFT	
*E9022	AIR PRESS CHANGE: DIVING	
*E9028	AIR PRESSURE CHANGE NEC	
*E9029	AIR PRESSURE CHANGE NOS	
*E903	TRAVEL AND MOTION	
*E9040	ABANDONMENT/LACK OF CARE	
*E9041	LACK OF FOOD	
*E9042	LACK OF WATER	
*E9043	EXPOSURE NEC	
*E9049	PRIVATION NOS	
*E9050	VENOMOUS SNAKE BITE	
*E9051	VENOMOUS SPIDER BITE	
*E9052	SCORPION STING	
*E9053	HORNET/WASP/BEE STING	
*E9054	CENTIPEDE BITE	
*E9055	VENOMOUS ARTHROPODS NEC	
*E9056	VENOM SEA ANIMALS/PLANTS	
*E9057	POISONING BY OTHER PLANT	
*E9058	VENOMOUS BITE/STING NEC	
*E9059	VENOMOUS BITE/STING NOS	
*E9060	DOG BITE	
*E9061	RAT BITE	
*E9062	NONVENOMOUS SNAKE BITE	
*E9063	ANIMAL BITE NEC	
*E9064	NONVENOM ARTHROPOD BITE	
*E9065	ANIMAL BITE NOS	
*E9068	INJ NEC CAUSED BY ANIMAL	
*E9069	INJ NOS CAUSED BY ANIMAL	
*E907	ACC DUE TO LIGHTNING	
*E908	CATACLYSMIC STORM/FLOOD*	
*E9080	ACCIDENT D/T HURRICANE	
*E9081	ACCIDENT D/T TORNADO	
*E9082	ACCIDENT D/T FLOODS	
*E9083	ACC D/T SNOW BLIZZARD	
*E9084	ACCIDENT D/T DUST STORM	
*E9088	ACCIDENT D/T STORM NEC	
*E9089	ACC D/T STORM/FLOOD NOS	
*E909	ACC D/T AVALANCH/EARTHQU*	
*E9090	ACC D/T EARTHQUAKES	
*E9091	ACC D/T VOLCANIC ERUPT	
*E9092	ACC D/T AVALANCHE	
*E9093	ACC D/T DAM COLLAPSE	
*E9094	ACC D/T TIDALWAVE NOS	

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
*E9098	ACC D/T ERUPTIONS NEC	
*E9099	ACC D/T ERUPTIONS NOS	
*E9100	WATER-SKIING ACCIDENT	
*E9101	SKIN/SCUBA DIVING ACC	
*E9102	SWIMMING ACCIDENT NOS	
*E9103	SWIMMING/DIVING ACC NEC	
*E9104	DROWNING IN BATHTUB	
*E9108	ACCIDENTAL DROWNING NEC	
*E9109	ACCIDENTAL DROWNING NOS	
*E911	RESP OBSTR-FOOD INHAL	
*E912	RESP OBSTR-INHAL OBJ NEC	
*E9130	SUFFOCAT IN BED/CRADLE	
*E9131	SUFFOCATION-PLASTIC BAG	
*E9132	SUFFOCATION-LACK OF AIR	
*E9133	CAVE-IN NOS	
*E9138	SUFFOCATION NEC	
*E9139	SUFFOCATION NOS	
*E914	FB ENTERING EYE	
*E915	FB ENTERING OTH ORIFICE	
*E916	STRUCK BY FALLING OBJECT	
*E9170	STRUCK IN SPORTS	
*E9171	CROWD ACCIDENT	
*E9172	STRUCK IN RUNNING WATER	
*E9179	STRUCK BY OBJ/PERSON NEC	
*E918	CAUGHT BETWEEN OBJECTS	
*E9190	MACHINE ACCID-AGRICULT	
*E9191	MACHINE ACCID-MINING	
*E9192	LIFTING MACHINE ACCIDENT	
*E9193	METALWORKING MACHINE ACC	
*E9194	WOODWORKING MACHINE ACC	
*E9195	PRIME MOVER MACHINE ACC	
*E9196	TRANSMISSION MACHINE ACC	
*E9197	EARTH MOVING MACHINE ACC	
*E9198	MACHINERY ACCIDENT NEC	
*E9199	MACHINERY ACCIDENT NOS	
*E9200	ACC-POWERED LAWN MOWER	
*E9201	ACC-POWER HAND TOOL NEC	
*E9202	ACC-POWER HOUSE APPLIANC	
*E9203	KNIFE/SWORD/DAGGER ACC	
*E9204	ACCID-OTHER HAND TOOLS	
*E9205	ACC-HYPODERMIC NEEDLE	
*E9208	ACC-CUTTING INSTRUM NEC	
*E9209	ACC-CUTTING INSTRUM NOS	
*E9210	BOILER EXPLOSION	
*E9211	GAS CYLINDER EXPLOSION	
*E9218	PRESS VESSEL EXPLOS NEC	
*E9219	PRESS VESSEL EXPLOS NOS	
*E9220	HANDGUN ACCIDENT	
*E9221	SHOTGUN ACCIDENT	
*E9222	HUNTING RIFLE ACCIDENT	
*E9223	MILITARY FIREARM ACCID	
*E9228	FIREARM ACCIDENT NEC	
*E9229	FIREARM ACCIDENT NOS	
*E9230	FIREWORKS ACCIDENT	
*E9231	BLASTING MATERIALS ACCID	
*E9232	EXPLOSIVE GASES ACCIDENT	
*E9238	EXPLOSIVES ACCIDENT NEC	
*E9239	EXPLOSIVES ACCIDENT NOS	
*E9240	ACC-HOT LIQUID & STEAM	
*E9241	ACCID-CAUSTIC SUBSTANCE	
*E9242	ACC-HOT TAP WATER	
*E9248	HOT SUBSTANCE ACCID NEC	
*E9249	HOT SUBSTANCE ACCID NOS	
*E9250	DOMESTIC WIRING ACCIDENT	
*E9251	ELECTR POWER GENERAT ACC	
*E9252	INDUST WIRING/MACHIN ACC	
*E9258	ELECTRIC CURRENT ACC NEC	
*E9259	ELECTRIC CURRENT ACC NOS	
*E9260	RADIOFREQ RADIAT EXPOSUR	
*E9261	INFRA-RED APPL RAD EXOS	
*E9262	VIS/ULTRAVIOL LGHT EXPOS	
*E9263	X-RAY/GAMMA RAY EXPOSURE	
*E9264	LASER EXPOSURE	
*E9265	RADIOACT ISOTOPE EXPOSUR	
*E9268	RADIATION EXPOSURE NEC	
*E9269	RADIATION EXPOSURE NOS	

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
*E927	ACCID FROM OVEREXERTION	
*E9280	ACC D/T WEIGHTLESS ENVIR	
*E9281	EXPOSURE TO NOISE	
*E9282	EXPOSURE TO VIBRATION	
*E9288	ACCIDENT NEC	
*E9289	ACCIDENT NOS	
*E9290	LATE EFF MOTOR VEHIC ACC	
*E9291	LATE EFF TRANSPORT ACC	
*E9292	LATE EFF ACC POISONING	
*E9293	LATE EFF ACCIDENTAL FALL	
*E9294	LATE EFF FIRE ACC	
*E9295	LATE EFF ENVIRONMENT ACC	
*E9298	LATE EFF ACCIDENT NEC	
*E9299	LATE EFF ACCIDENT NOS	
*E9300	ADV EFF PENICILLINS	
*E9301	ADV EFF ANTIFUNG ANTBIOT	
*E9302	ADV EFF CHLORAMPHENICOL	
*E9303	ADV EFF ERYTHROMYCIN	
*E9304	ADV EFF TETRACYCLINE	
*E9305	ADV EFF CEPHALOSPORIN	
*E9306	ADV EFF ANTMYCOB ANTBIOT	
*E9307	ADV EFF ANTINEOP ANTBIOT	
*E9308	ADV EFF ANTIBIOTICS NEC	
*E9309	ADV EFF ANTIBIOTIC NOS	
*E9310	ADV EFF SULFONAMIDES	
*E9311	ADV EFF ARSENIC ANTI-INF	
*E9312	ADV EFF METAL ANTI-INF	
*E9313	ADV EFF QUINOLINE	
*E9314	ADV EFF ANTIMALARIALS	
*E9315	ADV EFF ANTPROTAZOAL NEC	
*E9316	ADV EFF ANTHELMINTICS	
*E9317	ADV EFF ANTIVIRAL DRUGS	
*E9318	ADV EFF ANTIMYCOBAC NEC	
*E9319	ADV EFF ANTINFCT NEC/NOS	
*E9320	ADV EFF CORTICOSTEROIDS	
*E9321	ADV EFF ANDROGENS	
*E9322	ADV EFF OVARIAN HORMONES	
*E9323	ADV EFF INSULIN/ANTIDIAB	
*E9324	ADV EFF ANT PITUITARY	
*E9325	ADV EFF POST PITUITARY	
*E9326	ADV EFF PARATHYROID	
*E9327	ADV EFF THYROID & DERIV	
*E9328	ADV EFF ANTITHYROID AGNT	
*E9329	ADV EFF HORMONES NEC/NOS	
*E9330	ADV EFF ANALLRG/ANTEMET	
*E9331	ADV EFF ANTINEOPLASTIC	
*E9332	ADV EFF ACIDIFYING AGENT	
*E9333	ADV EFF ALKALIZING AGENT	
*E9334	ADV EFF ENZYMES NEC	
*E9335	ADV EFF VITAMINS NEC	
*E9338	ADV EFF SYSTEMIC AGT NEC	
*E9339	ADV EFF SYSTEMIC AGT NOS	
*E9340	ADV EFF IRON & COMPOUNDS	
*E9341	ADV EFF LIVER/ANTIANEMIC	
*E9342	ADV EFF ANTICOAGULANTS	
*E9343	ADV EFF VITAMIN K	
*E9344	ADV EFF FIBRINOLYSIS AGT	
*E9345	ADV EFF COAGULANTS	
*E9346	ADV EFF GAMMA GLOBULIN	
*E9347	ADV EFF BLOOD PRODUCTS	
*E9348	ADV EFF BLOOD AGENT NEC	
*E9349	ADV EFF BLOOD AGENT NOS	
*E9350	ADV EFF HEROIN	
*E9351	ADV EFF METHADONE	
*E9352	ADV EFF OPIATES	
*E9353	ADV EFF SALICYLATES	
*E9354	ADV EFF AROM ANALGSC NEC	
*E9355	ADV EFF PYRAZOLE DERIV	
*E9356	ADV EFF ANTIRHEUMATICS	
*E9357	ADV EFF NON-NARC ANALGSC	
*E9358	ADV EFF ANALGESICS NEC	
*E9359	ADV EFF ANALGESIC NOS	
*E9360	ADV EFF OXAZOLIDIN DERIV	
*E9361	ADV EFF HYDANTOIN DERIV	
*E9362	ADV EFF SUCCINIMIDES	
*E9363	ADV EFF ANTCONVL NEC/NOS	

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
*E9364	ADV EFF ANTI-PARKINSON	
*E9370	ADV EFF BARBITURATES	
*E9371	ADV EFF CHLORAL HYDRATE	
*E9372	ADV EFF PARALDEHYDE	
*E9373	ADV EFF BROMINE COMPNDS	
*E9374	ADV EFF METHAQUALONE	
*E9375	ADV EFF GLUTETHIMIDE	
*E9376	ADV EFF MIX SEDATIVE	
*E9378	ADV EFF SEDAT/HYPNOT NEC	
*E9379	ADV EFF SEDAT/HYPNOT NOS	
*E9380	ADV EFF CNS MUSCL DEPRES	
*E9381	ADV EFF HALOTHANE	
*E9382	ADV EFF GAS ANESTHET NEC	
*E9383	ADV EFF INTRAVEN ANESTH	
*E9384	ADV EFF GEN ANES NEC/NOS	
*E9385	ADV EFF TOPIC/INFIL ANES	
*E9386	ADV EFF NERVE-BLOCK ANES	
*E9387	ADV EFF SPINAL ANESTHET	
*E9389	ADV EFF LOC ANES NEC/NOS	
*E9390	ADV EFF ANTIDEPRESSANTS	
*E9391	ADV EFF PHENOTHIAZ TRANQ	
*E9392	ADV EFF BUTYROPHEN TRANQ	
*E9393	ADV EFF ANTIPSYCHOTC NEC	
*E9394	ADV EFF BENZODIAZ TRANQ	
*E9395	ADV EFF TRANQUILIZER NEC	
*E9396	ADV EFF HALLUCINOGENS	
*E9397	ADV EFF PSYCHOSTIMULANTS	
*E9398	ADV EFF PSYCHOTROPIC NEC	
*E9399	ADV EFF PSYCHOTROPIC NOS	
*E9400	ADV EFF ANALEPTICS	
*E9401	ADV EFF OPIAT ANTAGONIST	
*E9408	ADV EFF CNS STIMULNT NEC	
*E9409	ADV EFF CNS STIMULNT NOS	
*E9410	ADV EFF CHOLINERGICS	
*E9411	ADV EFF PARASYMPATHOLYTC	
*E9412	ADV EFF SYMPATHOMIMETICS	
*E9413	ADV EFF SYMPATHOLYTICS	
*E9419	ADV EFF AUTONOM AGNT NOS	
*E9420	ADV EFF CARD RHYTH REGUL	
*E9421	ADV EFF CARDIOTONICS	
*E9422	ADV EFF ANTILIPEMICS	
*E9423	ADV EFF GANGLION-BLOCK	
*E9424	ADV EFF CORONARY VASODIL	
*E9425	ADV EFF VASODILATORS NEC	
*E9426	ADV EFF ANTIHYPERTEN AGT	
*E9427	ADV EFF ANTIVARICOSE	
*E9428	ADV EFF CAPILLARY-ACT	
*E9429	ADV EFF CARDIOVASC NEC	
*E9430	ADV EFF ANTACIDS	
*E9431	ADV EFF IRRIT CATHARTIC	
*E9432	ADV EFF EMOLL CATHARTICS	
*E9433	ADV EFF CATHARTICS NEC	
*E9434	ADV EFF DIGESTANTS	
*E9435	ADV EFF ANTIDIARRHEA AGT	
*E9436	ADV EFF EMETICS	
*E9438	ADV EFF GI AGENT NEC	
*E9439	ADV EFF GI AGENT NOS	
*E9440	ADV EFF MERCURY DIURETIC	
*E9441	ADV EFF PURINE DIURETICS	
*E9442	ADV EFF ACETAZOLAMIDE	
*E9443	ADV EFF SALURETICS	
*E9444	ADV EFF DIURETICS NEC	
*E9445	ADV EFF ELECTROLYTE AGNT	
*E9446	ADV EFF MINERAL SALT NEC	
*E9447	ADV EFF URIC ACID METAB	
*E9450	ADV EFF OXYTOCIC AGENTS	
*E9451	ADV EFF SMOOTH MUSC RELX	
*E9452	ADV EFF SKELET MUSC RELX	
*E9453	ADV EFF MUSC AGT NEC/NOS	
*E9454	ADV EFF ANTITUSSIVES	
*E9455	ADV EFF EXPECTORANTS	
*E9456	ADV EFF ANTI-COMMON COLD	
*E9457	ADV EFF ANTIASTHMATICS	
*E9458	ADV EFF RESP DRG NEC/NOS	
*E9460	ADV EFF LOC ANTI-INFECTV	
*E9461	ADV EFF ANTIPRURITICS	

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
*E9462	ADV EFF LOCAL ASTRINGENT	
*E9463	ADV EFF EMOLLIENT/DEMULC	
*E9464	ADV EFF HAIR/SCALP PREP	
*E9465	ADV EFF EYE ANTI-INF/DRG	
*E9466	ADV EFF ENT ANTI-INF/DRG	
*E9467	ADV EFF TOPIC DENTAL DRG	
*E9468	ADV EFF SKIN AGENT NEC	
*E9469	ADV EFF SKIN AGENT NOS	
*E9470	ADV EFF DIETETICS	
*E9471	ADV EFF LIPOTROPIC DRUGS	
*E9472	ADV EFF ANTIDOTES NEC	
*E9473	ADV EFF ALCOHOL DETER	
*E9474	ADV EFF PHARMACEUT EXCIP	
*E9478	ADV EFF MEDICINAL NEC	
*E9479	ADV EFF MEDICINAL NOS	
*E9480	ADV EFF BCG VACCINE	
*E9481	ADV EFF TYPHOID VACCINE	
*E9482	ADV EFF CHOLERA VACCINE	
*E9483	ADV EFF PLAGUE VACCINE	
*E9484	ADV EFF TETANUS VACCINE	
*E9485	ADV EFF DIPHTHER VACCINE	
*E9486	ADV EFF PERTUSSIS VACCIN	
*E9488	ADV EFF BACT VAC NEC/NOS	
*E9489	ADV EFF MIX BACT VACCINE	
*E9490	ADV EFF SMALLPOX VACCINE	
*E9491	ADV EFF RABIES VACCINE	
*E9492	ADV EFF TYPHUS VACCINE	
*E9493	ADV EFF YELLOW FEVER VAC	
*E9494	ADV EFF MEASLES VACCINE	
*E9495	ADV EFF POLIO VACCINE	
*E9496	ADV EFF VIRAL VACC NEC	
*E9497	ADV EFF MIXED VIRAL-BACT	
*E9499	ADV EFF BIOLOGIC NEC/NOS	
*E9500	POISON-ANALGESICS	
*E9501	POISON-BARBITURATES	
*E9502	POISON-SEDAT/HYPNOTIC	
*E9503	POISON-PSYCHOTROPIC AGT	
*E9504	POISON-DRUG/MEDICIN NEC	
*E9505	POISON-DRUG/MEDICIN NOS	
*E9506	POISON-AGRICULT AGENT	
*E9507	POISON-CORROSIV/CAUSTIC	
*E9508	POISON-ARSENIC	
*E9509	POISON-SOLID/LIQUID NEC	
*E9510	POISON-PIPED GAS	
*E9511	POISON-GAS IN CONTAINER	
*E9518	POISON-UTILITY GAS NEC	
*E9520	POISON-EXHAUST GAS	
*E9521	POISON-CO NEC	
*E9528	POISON-GAS/VAPOR NEC	
*E9529	POISON-GAS/VAPOR NOS	
*E9530	INJURY-HANGING	
*E9531	INJURY-SUFF W PLAS BAG	
*E9538	INJURY-STRANG/SUFF NEC	
*E9539	INJURY-STRANG/SUFF NOS	
*E954	INJURY-SUBMERSION	
*E9550	INJURY-HANDGUN	
*E9551	INJURY-SHOTGUN	
*E9552	INJURY-HUNTING RIFLE	
*E9553	INJURY-MILITARY FIREARM	
*E9554	INJURY-FIREARM NEC	
*E9555	INJURY-EXPLOSIVES	
*E9559	INJURY-FIREARM/EXPL NOS	
*E956	INJURY-CUT INSTRUMENT	
*E9570	INJURY-JUMP FM RESIDENCE	
*E9571	INJURY-JUMP FM STRUC NEC	
*E9572	INJURY-JUMP FM NATUR SIT	
*E9579	INJURY-JUMP NEC	
*E9580	INJURY-MOVING OBJECT	
*E9581	INJURY-BURN, FIRE	
*E9582	INJURY-SCALD	
*E9583	INJURY-EXTREME COLD	
*E9584	INJURY-ELECTROCUTION	
*E9585	INJURY-MOTOR VEH CRASH	
*E9586	INJURY-AIRCRAFT CRASH	
*E9587	INJURY-CAUSTIC SUBSTANCE	
*E9588	INJURY-NEC	

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
*E9589	INJURY-NOS	
*E959	LATE EFF OF SELF-INJURY	
*E9600	UNARMED FIGHT OR BRAWL	
*E9601	RAPE	
*E961	ASSAULT-CORROSIV/CAUST	
*E9620	ASSAULT-POIS W MEDIC AGT	
*E9621	ASSAULT-POIS W SOLID/LIQ	
*E9622	ASSAULT-POIS W GAS/VAPOR	
*E9629	ASSAULT-POISONING NOS	
*E963	ASSAULT-HANGING/STRANGUL	
*E964	ASSAULT-SUBMERSION	
*E9650	ASSAULT-HANDGUN	
*E9651	ASSAULT-SHOTGUN	
*E9652	ASSAULT-HUNTING RIFLE	
*E9653	ASSAULT-MILITARY WEAPON	
*E9654	ASSAULT-FIREARM NEC	
*E9655	ASSAULT-ANTIPERSON BOMB	
*E9656	ASSAULT-GASOLINE BOMB	
*E9657	ASSAULT-LETTER BOMB	
*E9658	ASSAULT-EXPLOSIVE NEC	
*E9659	ASSAULT-EXPLOSIVE NOS	
*E966	ASSAULT-CUTTING INSTR	
*E9670	BATTER BY FATHER/STEPFTH	
*E9671	CHILD ABUSE BY PERS NEC	
*E9679	CHILD ABUSE NOS	
*E9680	ASSAULT-FIRE	
*E9681	ASSLT-PUSH FROM HI PLACE	
*E9682	ASSAULT-STRIKING W OBJ	
*E9683	ASSAULT-HOT LIQUID	
*E9684	ASSAULT-CRIMINAL NEGLECT	
*E9685	ASSLT-TRANSPORT VEHICLE	
*E9688	ASSAULT NEC	
*E9689	ASSAULT NOS	
*E969	LATE EFFECT ASSAULT	
*E970	LEGAL INTERVENT-FIREARM	
*E971	LEGAL INTERVENT-EXPLOSIV	
*E972	LEGAL INTERVENT-GAS	
*E973	LEGAL INTERVEN-BLUNT OBJ	
*E974	LEGAL INTERVEN-CUT INSTR	
*E975	LEGAL INTERVENTION NEC	
*E976	LEGAL INTERVENTION NOS	
*E977	LATE EFF-LEGAL INTERVENT	
*E978	LEGAL EXECUTION	
*E9800	UNDETERM POIS-ANALGESICS	
*E9801	UNDETERM POIS-BARBITURAT	
*E9802	UNDET POIS-SED/HYPN NEC	
*E9803	UNDETERM POIS-PSYCHOTROP	
*E9804	UNDET POIS-MED AGNT NEC	
*E9805	UNDET POIS-MED AGNT NOS	
*E9806	UNDET POIS-CORROS/CAUST	
*E9807	UNDET POIS-AGRICULT AGNT	
*E9808	UNDETER POIS-ARSENIC	
*E9809	UNDETER POIS-SOL/LIQ NEC	
*E9810	UNDETER POIS-PIPED GAS	
*E9811	UNDET POIS-CONTAINER GAS	
*E9818	UNDET POIS-UTIL GAS NEC	
*E9820	UNDETER POIS-EXHAUST GAS	
*E9821	UNDETERMIN POISON-CO NEC	
*E9828	UNDET POIS-GAS/VAPOR NEC	
*E9829	UNDET POIS-GAS/VAPOR NOS	
*E9830	UNDETERMIN CIRC-HANGING	
*E9831	UNDET CIRC-SUF PLAST BAG	
*E9838	UNDET CIRC-SUFFOCATE NEC	
*E9839	UNDET CIRC-SUFFOCATE NOS	
*E984	UNDETERM CIRC-SUBMERSION	
*E9850	UNDETERMIN CIRC-HANDGUN	
*E9851	UNDETERMIN CIRC-SHOTGUN	
*E9852	UNDET CIRC-HUNTING RIFLE	
*E9853	UNDET CIRC-MILITARY ARMS	
*E9854	UNDETER CIRC-FIREARM NEC	
*E9855	UNDETERM CIRC-EXPLOSIVE	
*E986	UNDET CIRC-CUT INSTRUMNT	
*E9870	UNDET CIRC-FALL RESIDENC	
*E9871	UNDET FALL STRUCTURE NEC	
*E9872	UNDET FALL NATURAL SITE	
*E9879	UNDET CIRC-FALL SITE NOS	

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
*E9880	UNDETERM CIRC-MOVING OBJ	
*E9881	UNDETERM CIRC-BURN, FIRE	
*E9882	UNDETERM CIRC-SCALD	
*E9883	UNDETERM CIRC-EXTRM COLD	
*E9884	UNDETERM CIRC-ELECTROCUT	
*E9885	UNDET CIRC-MOT VEH CRASH	
*E9886	UNDET CIRC-AIRCRFT CRASH	
*E9887	UNDET CIRC-CAUSTIC SUBST	
*E9888	UNDETERMIN CIRCUMST NEC	
*E9889	UNDETERMIN CIRCUMST NOS	
*E989	LATE EFF INJ-UNDET CIRC	
*E9900	WAR INJ:GASOLINE BOMB	
*E9909	WAR INJURY:FIRE NEC	
*E9910	WAR INJ:RUBBER BULLET	
*E9911	WAR INJURY:PELLETS	
*E9912	WAR INJURY:BULLET NEC	
*E9913	WAR INJ:ANTIPERSON BOMB	
*E9919	WAR INJ:FRAGMENTS NEC	
*E992	WAR INJ:MARINE EXPLOS	
*E993	WAR INJURY:EXPLOS NEC	
*E994	WAR INJ:AIRCRFT DESTRUC	
*E995	WAR INJUR-CONVEN WAR NEC	
*E996	WAR INJ:NUCLEAR WEAPONS	
*E9970	WAR INJURY:LASERS	
*E9971	WAR INJURY:BIOL WARFARE	
*E9972	WAR INJURY:GAS/FUM/CHEM	
*E9978	WAR INJ-UNCONVEN WAR NEC	
*E9979	WAR INJ-UNCONVEN WAR NOS	
*E998	WAR INJ:POST WAR OPERAT	
*E999	LATE EFF OF WAR INJURY	
V010	CHOLERA CONTACT	11
V011	TUBERCULOSIS CONTACT	11
V012	POLIOMYELITIS CONTACT	11
V013	SMALLPOX CONTACT	11
V014	RUBELLA CONTACT	11
V015	RABIES CONTACT	11
V016	VENEREAL DIS CONTACT	11
V017	VIRAL DIS CONTACT NEC	11
V018	COMMUNIC DIS CONTACT NEC	11
V019	COMMUNIC DIS CONTACT NOS	11
V020	CHOLERA CARRIER	11
V021	TYPHOID CARRIER	11
V022	AMEBIASIS CARRIER	11
V023	GI PATHOGEN CARRIER NEC	11
V024	DIPHTHERIA CARRIER	11
V025	BACTERIA DIS CARRIER NEC	11
V026	VIRAL HEPATITIS CARRIER*	11
V027	GONORRHEA CARRIER	11
V028	VENEREAL DIS CARRIER NEC	11
V029	CARRIER NEC	11
V030	VACCIN FOR CHOLERA	11
V031	VACC-TYPHOID-PARATYPHOID	11
V032	VACCIN FOR TUBERCULOSIS	11
V033	VACCIN FOR PLAGUE	11
V034	VACCIN FOR TULAREMIA	11
V035	VACCIN FOR DIPHTHERIA	11
V036	VACCIN FOR PERTUSSIS	11
V037	TETANUS TOXOID INOCULAT	11
V0381	ND VAC HMOPHLUS INFLNZ B	11
V0382	ND VAC STRPTCS PNEUMNI B	11
V0389	ND OTHER SPECF VACNATION	11
V039	VACCIN FOR BACT DIS NOS	11
V040	VACCIN FOR POLIOMYELITIS	11
V041	VACCIN FOR SMALLPOX	11
V042	VACCIN FOR MEASLES	11
V043	VACCIN FOR RUBELLA	11
V044	VACCIN FOR YELLOW FEVER	11
V045	VACCIN FOR RABIES	11
V046	VACCIN FOR MUMPS	11
V047	VACCIN FOR COMMON COLD	11
V048	VACCIN FOR INFLUENZA	11
V050	ARBOVIRUS ENCEPH VACCIN	11
V051	VACC ARBOVIRAL DIS NEC	11
V052	VACCIN FOR LEISHMANIASIS	11
V053	NEED PRPHYL VC VRL HEPAT	11
V054	NEED PRPHYL VC VARICELLA	11

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
V058	VACCIN FOR DISEASE NEC	11
V059	VACCIN FOR SINGL DIS NOS	11
V060	VACCIN FOR CHOLERA + TAB	11
V061	VACCIN FOR DTP	11
V062	VACCIN FOR DTP + TAB	11
V063	VACCIN FOR DTP + POLIO	11
V064	VAC-MEASLE-MUMPS-RUBELLA	11
V065	ND VAC TETANUS-DIPHTHRIA	11
V066	ND VAC STRP PNUMN/INFLNZ	11
V068	VAC-DIS COMBINATIONS NEC	11
V069	VAC-DIS COMBINATIONS NOS	11
V070	PROPHYLACTIC ISOLATION	11
V071	DESENSITIZA TO ALLERGENS	11
V072	PROPHYLACT IMMUNOTHERAPY	11
V0731	PROPHYLAC FLUORIDE ADMIN	11
V0739	OTHER PROPHYLAC CHEMOTHR	11
V074	NEED PSTMNPASL HRMN RPLC	11
V078	PROPHYLACTIC MEASURE NEC	11
V079	PROPHYLACTIC MEASURE NOS	11
V08	ASYMP HIV INFECTN STATUS	86
V090	INF MCRG RSTN PNCLLINS	97
V091	INF MCRG RSTN B-LACTAM	97
V092	INF MCRG RSTN MACROLIDES	97
V093	INF MCRG RSTN TTRCYCLN	97
V094	INF MCRG RSTN AMNGLCSDS	97
V0950	INF MCR RST QN FLR NT ML	97
V0951	INF MCRG RSTN QN FLRQ ML	97
V096	INF MCRG RSTN SULFNMIDES	97
V0970	INF MCR RST OTH AG NT ML	97
V0971	INF MCRG RSTN OTH AG MLT	97
V0980	INF MCR RST OT DRG NT ML	97
V0981	INF MCRG RSTN OTH DRG ML	97
V0990	INFC MCRG DRGRST NT MULT	97
V0991	INFC MCRG DRGRST MULT	97
V1000	HX OF GI MALIGNANCY NOS	11
V1001	HX OF TONGUE MALIGNANCY	11
V1002	HX-ORAL/PHARYNX MALG NEC	11
V1003	HX-ESOPHAGEAL MALIGNANCY	11
V1004	HX OF GASTRIC MALIGNANCY	11
V1005	HX OF COLONIC MALIGNANCY	11
V1006	HX-RECTAL & ANAL MALIGN	11
V1007	HX OF LIVER MALIGNANCY	11
V1009	HX OF GI MALIGNANCY NEC	11
V1011	HX-BRONCHOGENIC MALIGNAN	11
V1012	HX-TRACHEAL MALIGNANCY	11
V1020	HX-RESP ORG MALIGNAN NOS	11
V1021	HX-LARYNGEAL MALIGNANCY	11
V1022	HX-NOSE/EAR/SINUS MALIG	11
V1029	HX-INTRATHORACIC MAL NEC	11
V103	HX OF BREAST MALIGNANCY	11
V1040	HX-FEMALE GENIT MALG NOS	11
V1041	HX-CERVICAL MALIGNANCY	11
V1042	HX-UTERUS MALIGNANCY NEC	11
V1043	HX OF OVARIAN MALIGNANCY	11
V1044	HX-FEMALE GENIT MALG NEC	11
V1045	HX-MALE GENIT MALIG NOS	11
V1046	HX-PROSTATIC MALIGNANCY	11
V1047	HX-TESTICULAR MALIGNANCY	11
V1049	HX-MALE GENIT MALIG NEC	11
V1050	HX-URINARY MALIGNAN NOS	11
V1051	HX OF BLADDER MALIGNANCY	11
V1052	HX OF KIDNEY MALIGNANCY	11
V1059	HX-URINARY MALIGNAN NEC	11
V1060	HX OF LEUKEMIA NOS	11
V1061	HX OF LYMPHOID LEUKEMIA	11
V1062	HX OF MYELOID LEUKEMIA	11
V1063	HX OF MONOCYTIC LEUKEMIA	11
V1069	HX OF LEUKEMIA NEC	11
V1071	HX-LYMPHOSARCOMA	11
V1072	HX-HODGKIN'S DISEASE	11
V1079	HX-LYMPHATIC MALIGN NEC	11
V1081	HX OF BONE MALIGNANCY	11
V1082	HX-MALIG SKIN MELANOMA	11
V1083	HX-SKIN MALIGNANCY NEC	11
V1084	HX OF EYE MALIGNANCY	11
V1085	HX OF BRAIN MALIGNANCY	11

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
V1086	HX-MALIGN NERVE SYST NEC	11
V1087	HX OF THYROID MALIGNANCY	11
V1088	HX-ENDOCRINE MALIGN NEC	11
V1089	HX OF MALIGNANCY NEC	11
V109	HX OF MALIGNANCY NOS	11
V110	HX OF SCHIZOPHRENIA	11
V111	HX OF AFFECTIVE DISORDER	11
V112	HX OF NEUROSIS	11
V113	HX OF ALCOHOLISM	11
V118	HX-MENTAL DISORDER NEC	11
V119	HX-MENTAL DISORDER NOS	11
V1200	PRSNL HST UNSP NFCT PRST	11
V1201	PRSNL HST TUBERCULOSIS	11
V1202	PRSNL HST POLIOMYELITIS	11
V1203	PERSONAL HISTRY MALARIA	11
V1209	PRSNL HST OTH NFCT PARST	11
V121	HX-NUTRITION DEFICIENCY	11
V122	HX-ENDOCR/META/IMMUN DIS	11
V123	HX-BLOOD DISEASES	11
V1250	HX-CIRCULATORY DIS NOS	11
V1251	HX-VEN THROMBOSIS/EMBOLS	11
V1252	HX-THROMBOPHLEBITIS	11
V1259	HX-CIRCULATORY DIS NEC	11
V126	HX-RESPIRATORY SYS DIS	11
V1270	PRSNL HST UNSPC DGSTV DS	11
V1271	PRSNL HST PEPTIC ULCR DS	11
V1272	PRSNL HST COLONIC POLYPS	11
V1279	PRSNL HST OT SPF DGST DS	11
V1300	PRSNL HST URNR DSRD UNSP	11
V1301	PRSNL HST URNR DSRD CALC	11
V1309	PRSN HST OT SPF URN DSRD	11
V131	HX-TROPHOBLASTIC DISEASE	11
V132	HX-GENITAL/OBSTETRIC DIS	11
V133	HX-SKIN/SUBCUTAN TIS DIS	11
V134	HX OF ARTHRITIS	11
V135	HX-MUSCULOSKELET DIS NEC	11
V136	HX-CONGENITAL MALFORM	11
V137	HX-PERINATAL PROBLEMS	11
V138	HX OF DISEASES NEC	11
V139	HX OF DISEASE NOS	11
V140	HX-PENICILLIN ALLERGY	11
V141	HX-ANTIBIOT ALLERGY NEC	11
V142	HX-SULFONAMIDES ALLERGY	11
V143	HX-ANTI-INFECT ALLERGY	11
V144	HX-ANESTHETIC ALLERGY	11
V145	HX-NARCOTIC ALLERGY	11
V146	HX-ANALGESIC ALLERGY	11
V147	HX-VACCINE ALLERGY	11
V148	HX-DRUG ALLERGY NEC	11
V149	HX-DRUG ALLERGY NOS	11
V150	HX OF ALLERGY NEC	11
V151	HX-MAJOR CARDIOVASC SURG	11
V152	HX-MAJOR ORGAN SURG NEC	11
V153	HX OF IRRADIATION	11
V155	HX OF INJURY	11
V156	HX OF POISONING	11
V157	HX OF CONTRACEPTION	11
V1581	HX OF PAST NONCOMPLIANCE	11
V1582	HISTORY OF TOBACCO USE	11
V1584	HX-EXPOSURE ASBESTOS	11
V1585	HX-EXPS HAZRD BODY FLUID	11
V1586	HX-EXPOSURE TO LEAD	11
V1589	HX-HEALTH HAZARDS NEC	11
V159	HX-HEALTH HAZARD NOS	11
V160	FAMILY HX-GI MALIGNANCY	11
V161	FM HX-TRACH/BRONCHOG MAL	11
V162	FAM HX-INTRATHORACIC MAL	11
V163	FAMILY HX-BREAST MALIG	11
V165	FAMILY HX-URINARY MALIG	11
V166	FAMILY HX-LEUKEMIA	11
V167	FAM HX-LYMPH NEOPLAS NEC	11
V168	FAMILY HX-MALIGNANCY NEC	11
V169	FAMILY HX-MALIGNANCY NOS	11
V170	FAM HX-PSYCHIATRIC COND	11
V171	FAMILY HX-STROKE	11
V172	FAM HX-NEUROLOG DIS NEC	11

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
V173	FAM HX-ISCHEM HEART DIS	11
V174	FAM HX-CARDIOVAS DIS NEC	11
V175	FAMILY HX-ASTHMA	11
V176	FAM HX-CHR RESP COND NEC	11
V177	FAMILY HX-ARTHRITIS	11
V178	FAM HX-MUSCLOSKL DIS NEC	11
V180	FAM HX-DIABETES MELLITUS	11
V181	FM HX-ENDO/METAB DIS NEC	11
V182	FAMILY HX-ANEMIA	11
V183	FAM HX-BLOOD DISORD NEC	11
V184	FAM HX-MENTAL RETARDAT	11
V185	FAMILY HX-GI DISORDERS	11
V186	FAMILY HX-KIDNEY DISEASE	11
V187	FAMILY HX-GU DISEASE NEC	11
V188	FM HX-INFECT/PARASIT DIS	11
V190	FAMILY HX-BLINDNESS	11
V191	FAMILY HX-EYE DISORD NEC	11
V192	FAMILY HX-DEAFNESS	11
V193	FAMILY HX-EAR DISORD NEC	11
V194	FAMILY HX-SKIN CONDITION	11
V195	FAM HX-CONGEN ANOMALIES	11
V196	FAMILY HX-ALLERGIC DIS	11
V197	CONSANGUINITY	11
V198	FAMILY HX-CONDITION NEC	11
V200	FOUNDLING HEALTH CARE	11
V201	CARE OF HEALTHY CHLD NEC	11
V202	ROUTIN CHILD HEALTH EXAM	11
V210	RAPID CHILDHOOD GROWTH	11
V211	PUBERTY	11
V212	ADOLESCENCE GROWTH NEC	11
V218	CONSTIT STATE IN DEV NEC	11
V219	CONSTIT STATE IN DEV NOS	11
V220	SUPERVIS NORMAL 1ST PREG	57
V221	SUPERVIS OTH NORMAL PREG	57
*V222	PREG STATE, INCIDENTAL	.....
V230	PREG W HX OF INFERTILITY	57
V231	PREG W HX-TROPHOBLAS DIS	57
V232	PREG W HX OF ABORTION	57
V233	GRAND MULTIPARITY	57
V234	PREG W POOR OBSTETRIC HX	57
V235	PREG W POOR REPRODUCT HX	57
V237	INSUFFICNT PRENATAL CARE	57
V238	SUPRV HIGH-RISK PREG NEC	57
V239	SUPRV HIGH-RISK PREG NOS	57
V240	POSTPART CARE AFTER DEL	57
V241	POSTPART CARE-LACTATION	57
V242	ROUT POSTPART FOLLOW-UP	57
V2501	PRESCRIP-ORAL CONTRACEPT	11
V2502	INITIATE CONTRACEPT NEC	11
V2509	CONTRACEPTIVE MANGMT NEC	11
V251	INSERTION OF IUD	11
V252	STERILIZATION	11
V253	MENSTRUAL EXTRACTION	56
V2540	CONTRACEPT SURVEILL NOS	11
V2541	CONTRACEPT PILL SURVEILL	11
V2542	IUD SURVEILLANCE	11
V2543	SRVL MPLNT SBDRM CNTRCEP	11
V2549	CONTRACEPT SURVEILL NEC	11
V255	NSRT MPLNT SBDRM CNTRCEP	11
V258	CONTRACEPTIVE MANGMT NEC	11
V259	CONTRACEPTIVE MANGMT NOS	11
V260	TUBOPLASTY OR VASOPLASTY	11
V261	ARTIFICIAL INSEMINATION	11
V262	PROCREATIVE MGMT-INVEST	11
V263	GENETIC COUNSELING	11
V264	PROCREATIVE MGMT-COUNSEL	11
V268	PROCREATIVE MANGMT NEC	11
V269	PROCREATIVE MANGMT NOS	11
*V270	DELIVER-SINGLE LIVEBORN	.....
*V271	DELIVER-SINGLE STILLBORN	.....
*V272	DELIVER-TWINS, BOTH LIVE	.....
*V273	DEL-TWINS, 1 NB, 1 SB	.....
*V274	DELIVER-TWINS, BOTH SB	.....
*V275	DEL-MULT BIRTH, ALL LIVE	.....
*V276	DEL-MULT BRTH, SOME LIVE	.....
*V277	DEL-MULT BIRTH, ALL SB	.....

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
*V279	OUTCOME OF DELIVERY NOS	
V280	SCREENING-CHROMOSOM ANOM	57
V281	SCREEN-ALPHAFETOPROTEIN	57
V282	SCREEN BY AMNIOCENT NEC	57
V283	SCREEN-FETAL MALFORM	57
V284	SCREEN-FETAL RETARDATION	57
V285	SCREEN-ISOIMMUNIZATION	57
V288	ANTENATAL SCREENING NEC	57
V289	ANTENATAL SCREENING NOS	57
V290	NB OBSRV SUSPCT INFECT	11
V291	NB OBSRV SUSPCT NEURLGCL	11
V292	OBSRV NB SUSPC RESP COND	11
V298	NB OBSRV OTH SUSPCT COND	11
V299	NB OBSRV UNSP SUSPCT CND	11
V3000	SINGLE LB IN-HOSP W/O CS	57
V3001	SINGLE LB IN-HOSP W CS	57
V301	SINGL LIVEBRN-BEFORE ADM	57
V302	SINGLE LIVEBORN-NONHOSP	57
V3100	TWIN-MATE LB-HOSP W/O CS	57
V3101	TWIN-MATE LB-IN HOS W CS	57
V311	TWIN, MATE LB-BEFORE ADM	57
V312	TWIN, MATE LB-NONHOSP	57
V3200	TWIN-MATE SB-HOSP W/O CS	57
V3201	TWIN-MATE SB-HOSP W CS	57
V321	TWIN, MATE SB-BEFORE ADM	57
V322	TWIN, MATE SB-NONHOSP	57
V3300	TWIN-NOS-IN HOSP W/O CS	57
V3301	TWIN-NOS-IN HOSP W CS	57
V331	TWIN NOS-BEFORE ADMISSN	57
V332	TWIN NOS-NONHOSP	57
V3400	OTH MULT LB-HOSP W/O CS	57
V3401	OTH MULT LB-IN HOSP W CS	57
V341	OTH MULT NB-BEFORE ADM	57
V342	OTH MULTIPLE NB-NONHOSP	57
V3500	OTH MULT SB-HOSP W/O CS	57
V3501	OTH MULT SB-IN HOSP W CS	57
V351	OTH MULT SB-BEFORE ADM	57
V352	OTH MULTIPLE SB-NONHOSP	57
V3600	MULT LB/SB-IN HOS W/O CS	57
V3601	MULT LB/SB-IN HOSP W CS	57
V361	MULT NB/SB-BEFORE ADM	57
V362	MULTIPLE NB/SB-NONHOSP	57
V3700	MULT BRTH NOS-HOS W/O CS	57
V3701	MULT BIRTH NOS-HOSP W CS	57
V371	MULT BRTH NOS-BEFORE ADM	57
V372	MULT BIRTH NOS-NONHOSP	57
V3900	LIVEBORN NOS-HOSP W/O CS	57
V3901	LIVEBORN NOS-HOSP W CS	57
V391	LIVEBORN NOS-BEFORE ADM	57
V392	LIVEBORN NOS-NONHOSP	57
V400	PROBLEMS WITH LEARNING	91
V401	PROB WITH COMMUNICATION	91
V402	MENTAL PROBLEMS NEC	91
V403	BEHAVIORAL PROBLEMS NEC	91
V409	MENTAL/BEHAVIOR PROB NOS	91
V410	PROBLEMS WITH SIGHT	11
V411	EYE PROBLEMS NEC	11
V412	PROBLEMS WITH HEARING	11
V413	EAR PROBLEMS NEC	11
V414	VOICE PRODUCTION PROBLEM	11
V415	SMELL AND TASTE PROBLEM	11
V416	PROBLEM W SWALLOWING	11
V417	SEXUAL FUNCTION PROBLEM	91
V418	PROBL W SPECIAL FUNC NEC	91
V419	PROBL W SPECIAL FUNC NOS	91
V420	KIDNEY TRANSPLANT STATUS	53
V421	HEART TRANSPLANT STATUS	36
V422	HEART VALVE TRANSPLANT	36
V423	SKIN TRANSPLANT STATUS	18
V424	BONE TRANSPLANT STATUS	24
V425	CORNEA TRANSPLANT STATUS	68
V426	LUNG TRANSPLANT STATUS	33
V427	LIVER TRANSPLANT STATUS	41
V429	TRANSPLANT STATUS NOS	11
V430	EYE REPLACEMENT NEC	68
V431	LENS REPLACEMENT NEC	11

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
V432	HEART REPLACEMENT NEC	36
V433	HEART VALVE REPLAC NEC	36
V434	BLOOD VESSEL REPLAC NEC	36
V435	BLADDER REPLACEMENT NEC	53
V4360	JOINT REPLACED UNSPCF	11
V4361	JOINT REPLACED SHOULDER	11
V4362	JOINT REPLACED ELBOW	11
V4363	JOINT REPLACED WRIST	11
V4364	JOINT REPLACED HIP	11
V4365	JOINT REPLACED KNEE	11
V4366	JOINT REPLACED ANKLE	11
V4369	OTH SPCF JOINT REPLACED	11
V437	LIMB REPLACEMENT NEC	24
V4381	LARYNX REPLACEMENT	11
V4382	BREAST REPLACEMENT	11
V4389	ORGAN/TISS REPLACMNT NEC	11
V440	TRACHEOSTOMY STATUS	11
V441	GASTROSTOMY STATUS	11
V442	ILEOSTOMY STATUS	11
V443	COLOSTOMY STATUS	11
V444	ENTEROSTOMY STATUS NEC	11
V445	CYSTOSTOMY STATUS	11
V446	URINOSTOMY STATUS NEC	11
V447	ARTIFICIAL VAGINA STATUS	11
V448	ARTIF OPEN STATUS NEC	11
V449	ARTIF OPEN STATUS NOS	11
V4500	STATUS CARDC DVCE UNSPCF	11
V4501	STATUS CARDIAC PACEMAKER	11
V4502	STATUS AUTM CRD DFBRLTR	11
V4509	STATUS OTH SPCF CRDC DVC	11
V451	RENAL DIALYSIS STATUS	11
V452	VENTRICULAR SHUNT STATUS	11
V453	INTESTINAL BYPASS STATUS	11
V454	ARTHRODESIS STATUS	11
V4551	PRSC NTRUTR CNTRCPTV DVC	11
V4552	PRSC SBDRML CNTRCP MPLNT	11
V4559	PRSC OTHER CNTRCPTV DVC	11
V4581	AORTOCORONARY BYPASS	11
V4582	STATUS-POST PTCA	11
V4583	BREAST IMPL REMOV STATUS	11
V4589	POSTSURGICAL STATES NEC	11
V460	DEPENDENCE ON ASPIRATOR	33
V461	DEPENDENCE ON RESPIRATOR	33
V468	MACHINE DEPENDENCE NEC	11
V469	MACHINE DEPENDENCE NOS	11
V470	INTERN ORGAN DEFICIENCY	11
V471	MECH PROB W INTERNAL ORG	11
V472	CARDIORESPIRAT PROBL NEC	11
V473	DIGESTIVE PROBLEMS NEC	11
V474	URINARY PROBLEMS NEC	11
V475	GENITAL PROBLEMS NEC	11
V479	PROBL W INTERNAL ORG NOS	11
V480	DEFICIENCIES OF HEAD	11
V481	DEFICIENCIES NECK/TRUNK	11
V482	MECHANICAL PROB W HEAD	11
V483	MECH PROB W NECK & TRUNK	11
V484	SENSORY PROBLEM W HEAD	11
V485	SENSOR PROB W NECK/TRUNK	11
V486	DISFIGUREMENTS OF HEAD	11
V487	DISFIGUREMENT NECK/TRUNK	11
V488	PROB-HEAD/NECK/TRUNK NEC	11
V489	PROB-HEAD/NECK/TRUNK NOS	11
V490	DEFICIENCIES OF LIMBS	11
V491	MECHANICAL PROB W LIMBS	11
V492	MOTOR PROBLEMS W LIMBS	11
V493	SENSORY PROBLEMS W LIMBS	11
V494	DISFIGUREMENTS OF LIMBS	11
V495	LIMB PROBLEMS NEC	11
V4960	STATUS AMPUT UP LMB NOS	11
V4961	STATUS AMPUT THUMB	11
V4962	STATUS AMPUT OTH FINGERS	11
V4963	STATUS AMPUT HAND	11
V4964	STATUS AMPUT WRIST	11
V4965	STATUS AMPUT BELOW ELBOW	11
V4966	STATUS AMPUT ABOVE ELBOW	11
V4967	STATUS AMPUT SHOULDER	11

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
V4970	STATUS AMPUT LWR LMB NOS	11
V4971	STATUS AMPUT GREAT TOE	11
V4972	STATUS AMPUT OTHR TOE(S)	11
V4973	STATUS AMPUT FOOT	11
V4974	STATUS AMPUT ANKLE	11
V4975	STATUS AMPUT BELOW KNEE	11
V4976	STATUS AMPUT ABOVE KNEE	11
V4977	STATUS AMPUT HIP	11
V498	PROBL INFLU HEALTH NEC	11
V499	PROBL INFLU HEALTH NOS	11
V500	HAIR TRANSPLANT	11
V501	PLASTIC SURGERY NEC	11
V502	ROUTINE CIRCUMCISION	11
V503	EAR PIERCING	11
V5041	PRPHYLCT ORGN RMVL BRST	11
V5042	PRPHYLCT ORGN RMVL OVARY	11
V5049	PRPHYLCT ORGN RMVL OTHER	11
V508	ELECTIVE SURGERY NEC	11
V509	ELECTIVE SURGERY NOS	11
V51	AFTERCARE W PLASTIC SURG	18
V520	FITTING ARTIFICIAL ARM	24
V521	FITTING ARTIFICIAL LEG	24
V522	FITTING ARTIFICIAL EYE	11
V523	FITTING DENTAL PROSTHES	31
V524	FIT/ADJ BREAST PROS/IMPL	18
V528	FITTING PROSTHESIS NEC	24
V529	FITTING PROSTHESIS NOS	24
V531	FIT CONTACT LENS/GLASSES	68
V532	ADJUSTMENT HEARING AID	31
V533	ADJUST CARDIAC PACEMAKER*	36
V5331	FTNG CARDIAC PACEMAKER	11
V5332	FTNG AUTMTC DFIBRILLATOR	11
V5339	FTNG OTH CARDIAC DEVICE	11
V534	FIT ORTHODONTIC DEVICE	31
V535	FIT/ADJ INTES APPL NEC	41
V536	FITTING URINARY DEVICES	53
V537	FIT ORTHOPEDIC DEVICES	24
V538	ADJUSTMENT OF WHEELCHAIR	24
V539	ADJUSTMNT DEVICE NEC/NOS	24
V540	REMOVAL INT FIXATION DEV	11
V548	ORTHOPEDIC AFTERCARE NEC	24
V549	ORTHOPEDIC AFTERCARE NOS	24
V550	ATTEN TO TRACHEOSTOMY	31
V551	ATTEN TO GASTROSTOMY	41
V552	ATTEN TO ILEOSTOMY	41
V553	ATTEN TO COLOSTOMY	41
V554	ATTEN TO ENTEROSTOMY NEC	41
V555	ATTEN TO CYSTOSTOMY	53
V556	ATTEN TO URINOSTOMY NEC	53
V557	ATTEN ARTIFICIAL VAGINA	56
V558	ATTN TO ARTIF OPEN NEC	11
V559	ATTN TO ARTIF OPEN NOS	11
V560	RENAL DIALYSIS ENCOUNTER	11
V561	FIT/ADJ DIALYSIS CATHETR	
V568	DIALYSIS ENCOUNTER, NEC	53
V570	BREATHING EXERCISES	11
V571	PHYSICAL THERAPY NEC	11
V5721	ENCNTR OCCUPATNAL THRPY	11
V5722	ENCNTR VOCATIONAL THRPY	11
V573	SPEECH THERAPY	11
V574	ORTHOPTIC TRAINING	11
V5781	ORTHOTIC TRAINING	24
V5789	REHABILITATION PROC NEC	11
V579	REHABILITATION PROC NOS	11
V580	RADIOTHERAPY ENCOUNTER	11
V581	CHEMOTHERAPY ENCOUNTER	11
V582	BLOOD TRANSFUSION, NO DX	11
V583	ATTEN-SURG DRESSNG/SUTUR	11
V584	POSTSURG AFTERCARE NEC*	11
V5841	ENCNTR PLND PO WND CLSR	11
V5849	POSTOP OTH SPECFD AFTRCR	11
V585	ORTHODONTICS AFTERCARE	31
V5861	LONG-TERM USE ANTICOAGUL	36
V5869	LONG-TERM USE MEDS NEC	11
V5881	FIT/ADJ VASCULAR CATHETR	11
*V5882	FIT/ADJ NON-VSC CATH NEC	

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
V5889	OTHER SPECFIED AFTERCARE	11
V589	AFTERCARE NOS	11
V5901	BLOOD DONOR-WHOLE BLOOD	11
V5902	BLOOD DONOR-STEM CELLS	11
V5909	BLOOD DONOR NEC	11
V591	SKIN DONOR	11
V592	BONE DONOR	11
V593	BONE MARROW DONOR	11
V594	KIDNEY DONOR	11
V595	CORNEA DONOR	11
V596	LIVER DONOR	11
V598	ORG OR TISSUE DONOR NEC	11
V599	ORG OR TISSUE DONOR NOS	11
V600	LACK OF HOUSING	91
V601	INADEQUATE HOUSING	91
V602	ECONOMIC PROBLEM	91
V603	PERSON LIVING ALONE	91
V604	NO FAMILY ABLE TO CARE	91
V605	HOLIDAY RELIEF CARE	91
V606	PERSON IN RESIDENT INST	91
V608	HOUSING/ECONO CIRCUM NEC	91
V609	HOUSING/ECONO CIRCUM NOS	91
V610	FAMILY DISRUPTION	91
V6120	CNSL PRNT-CHLD PROB NOS	91
V6121	CNSL VICTIM CHILD ABUSE	91
V6129	PARENT-CHILD PROBLEM NEC	91
V613	PROBLEM W AGED PARENT	91
V6141	ALCOHOLISM IN FAMILY	91
V6149	FAMILY HEALTH PROBL NEC	91
V615	MULTIPARITY	56
V616	ILLEGITIMATE PREGNANCY	91
V617	UNWANTED PREGNANCY NEC	91
V618	FAMILY CIRCUMSTANCES NEC	91
V619	FAMILY CIRCUMSTANCE NOS	91
V620	UNEMPLOYMENT	91
V621	ADVERSE EFF-WORK ENVIRON	91
V622	OCCUP CIRCUMSTANCES NEC	91
V623	EDUCATIONAL CIRCUMSTANCE	91
V624	SOCIAL MALADJUSTMENT	91
V625	LEGAL CIRCUMSTANCES	91
V626	REFUSAL OF TREATMENT	91
V6281	INTERPERSONAL PROBL NEC	91
V6282	BEREAVEMENT, UNCOMPLICAT	91
V6289	PSYCHOLOGICAL STRESS NEC	91
V629	PSYCHOSOCIAL CIRCUM NOS	91
V630	HOME REMOTE FROM HOSPITL	91
V631	NO MEDICAL SERV IN HOME	91
V632	WAIT ADM TO OTH FACILITY	91
V638	NO MED FACILITIES NEC	91
V639	NO MED FACILITIES NOS	91
V640	NO VACCIN/CONTRAINDICAT	11
V641	NO PROC/CONTRAINDICATION	11
V642	NO PROC/PATIENT DECISION	11
V643	NO PROC FOR REASONS NEC	11
V650	HEALTHY PERSON W SICK	11
V651	PERSON CONSULT FOR ANOTH	91
V652	PERSON FEIGNING ILLNESS	91
V653	DIETARY SURVEIL/COUNSEL	82
V6540	COUNSELING NOS	91
V6541	EXERCISE COUNSELING	11
V6542	COUNSLNG SBSTN USE ABUSE	91
V6543	COUNSELING INJRY PREVENT	11
V6544	HIV COUNSELING	86
V6545	CONSLN OT SEX TRNSMT DIS	97
V6549	OTHER SPECFD COUNSELING	11
V655	PERSN W FEARED COMPLAINT	91
V658	REASON FOR CONSULT NEC	91
V659	REASON FOR CONSULT NOS	91
V660	SURGICAL CONVALESCENCE	11
V661	RADIOTHERAPY CONVALESCEN	11
V662	CHEMOTHERAPY CONVALESCEN	11
V663	MENTAL DIS CONVALESCENCE	11
V664	FRACTURE TREATMNT CONVAL	11
V665	CONVALESCENCE NEC	11
V666	COMB TREATMENT CONVALES	11
V669	CONVALESCENCE NOS	11

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
V670	SURGERY FOLLOW-UP	11
V671	RADIOTHERAPY FOLLOW-UP	11
V672	CHEMOTHERAPY FOLLOW-UP	11
V673	PSYCHIATRIC FOLLOW-UP	91
V674	FU EXAM TREATD HEALED FX	11
V6751	HIGH-RISK RX NEC EXAM	11
V6759	FOLLOW-UP EXAM NEC	11
V676	COMB TREATMENT FOLLOW-UP	11
V679	FOLLOW-UP EXAM NOS	11
V680	ISSUE MEDICAL CERTIFICAT	91
V681	ISSUE REPEAT PRESCRIPT	11
V682	REQUEST EXPERT EVIDENCE	11
V6881	REFERRAL-NO EXAM/TREAT	11
V6889	ADMINISTRTVE ENCOUNT NEC	11
V689	ADMINISTRTVE ENCOUNT NOS	11
V690	LACK OF PHYSICAL EXERCSE	11
V691	INAPPRT DIET EAT HABITS	11
V692	HIGH-RISK SEXUAL BEHAVR	97
V693	GAMBLING AND BETTING	91
V698	OTH PRBLMS RLTD LFSTYLE	91
V699	PRBLM RLTD LFSTYLE NOS	91
V700	ROUTINE MEDICAL EXAM	11
V701	PSYCH EXAM-AUTHORITY REQ	91
V702	GEN PSYCHIATRIC EXAM NEC	91
V703	MED EXAM NEC-ADMIN PURP	11
V704	EXAM-MEDICOLEGAL REASONS	11
V705	HEALTH EXAM-GROUP SURVEY	11
V706	HEALTH EXAM-POP SURVEY	11
V707	EXAM-CLINICAL RESEARCH	11
V708	GENERAL MEDICAL EXAM NEC	11
V709	GENERAL MEDICAL EXAM NOS	11
V7101	OBSV-ADULT ANTISOC BEHAV	91
V7102	OBSV-ADOLESC ANTISOC BEH	91
V7109	OBSERV-MENTAL COND NEC	91
V711	OBSV-SUSPCT MAL NEOPLASM	88
V712	OBSERV-SUSPECT TB	11
V713	OBSERV-WORK ACCIDENT	11
V714	OBSERV-ACCIDENT NEC	11
V715	OBSERV FOLLOWING RAPE	91
V716	OBSERV-INFLICTED INJ NEC	11
V717	OBS-SUSP CARDIOVASC DIS	11
V718	OBSERV-SUSPECT COND NEC	11
V719	OBSERV-SUSPECT COND NOS	11
V720	EYE & VISION EXAMINATION	68
V721	EAR & HEARING EXAM	31
V722	DENTAL EXAMINATION	31
V723	GYNECOLOGIC EXAMINATION	56
V724	PREG EXAM-PREG UNCONFIRM	56
V725	RADIOLOGICAL EXAM NEC	11
V726	LABORATORY EXAMINATION	11
V727	SKIN/SENSITIZATION TESTS	11
V7281	PREOP CARDIOVSCLR EXAM	11
V7282	PREOP RESPIRATORY EXAM	11
V7283	OTH SPCF PREOP EXAM	11
V7284	PREOP EXAM UNSPCF	11
V7285	OTH SPECIFIED EXAM	11
V729	EXAMINATION NOS	11
V730	SCREENING-POLIOMYELITIS	11
V731	SCREENING FOR SMALLPOX	11
V732	SCREENING FOR MEASLES	11
V733	SCREENING FOR RUBELLA	11
V734	SCREENING-YELLOW FEVER	11
V735	SCREENING-ARBOVIRUS DIS	11
V736	SCREENING FOR TRACHOMA	11
V7388	SCRN OTH SPCF CHLMYD DIS	11
V7389	SCRN OTH SPCF VIRAL DIS	11
V7398	SCRN UNSPCF CHLMYD DIS	11
V7399	SCRN UNSPCF VIRAL DIS	11
V740	SCREENING FOR CHOLERA	11
V741	SCREENING-PULMONARY TB	11
V742	SCREENING FOR LEPROSY	11
V743	SCREENING FOR DIPHTHERIA	11
V744	SCREEN-BACT CONJUNCTIVIT	11
V745	SCREEN FOR VENERAL DIS	11
V746	SCREENING FOR YAWS	11
V748	SCREEN-BACTERIAL DIS NEC	11

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ADDENDUM F.—ICD–9 CODES WITH MAJOR DIAGNOSTIC CATEGORIES (MDCs) FOR PAYMENT OF MEDICAL VISITS UNDER THE HOSPITAL OUTPATIENT PPS—Continued

ICD–9	ICD–9 Description	MDC
V749	SCREEN-BACTERIAL DIS NOS	11
V750	SCREEN-RICKETTSIAL DIS	11
V751	SCREENING FOR MALARIA	11
V752	SCREEN FOR LEISHMANIASIS	11
V753	SCREEN-TRYPANOSOMIASIS	11
V754	SCREEN-MYCOTIC INFECT	11
V755	SCREEN-SCHISTOSOMIASIS	11
V756	SCREEN FOR FILARIASIS	11
V757	SCREEN FOR HELMINTHIASIS	11
V758	SCREEN-PARASITIC DIS NEC	11
V759	SCREEN FOR INFEC DIS NOS	11
V760	SCREEN MAL NEOP-RESP ORG	11
V762	SCREEN MAL NEOP-CERVIX	11
V763	SCREEN MAL NEOP-BLADDER	11
V7641	SCREEN MAL NEOP-RECTUM	11
V7642	SCREEN MAL NEOP-ORAL CAV	11
V7643	SCREEN MAL NEOP-SKIN	11
V7649	SCREEN MAL NEOP-SITE NEC	11
V768	SCREEN-NEOPLASM NEC	11
V769	SCREEN-NEOPLASM NOS	11
V770	SCREEN-THYROID DISORDER	11
V771	SCREEN-DIABETES MELLITUS	11
V772	SCREEN FOR MALNUTRITION	11
V773	SCREEN-PHENYLKETONURIA	11
V774	SCREEN FOR GALACTOSEMIA	11
V775	SCREENING FOR GOUT	11
V776	SCREEN-CYSTIC FIBROSIS	11
V777	SCREEN-INBORN ERR METAB	11
V778	SCREENING FOR OBESITY	11
V779	SCREEN-ENDOC/NUT/MET NEC	11
V780	SCREEN-IRON DEFIC ANEMIA	11
V781	SCREEN-DEFIC ANEMIA NEC	11
V782	SCREEN-SICKLE CELL DIS	11
V783	SCRN-HEMOGLOBINOPATH NEC	11
V788	SCREEN-BLOOD DIS NEC	11
V789	SCREEN-BLOOD DIS NOS	11
V790	SCREENING FOR DEPRESSION	11
V791	SCREENING FOR ALCOHOLISM	11
V792	SCREEN-MENTAL RETARDAT	11
V793	SCREEN-DEVELOPMENT PROB	11
V798	SCREEN-MENTAL DIS NEC	11
V799	SCREEN-MENTAL DIS NOS	11
V800	SCREEN-NEUROLOGICAL COND	11
V801	SCREENING FOR GLAUCOMA	11
V802	SCREENING-EYE COND NEC	11
V803	SCREENING FOR EAR DIS	11
V810	SCRN-ISCHEMIC HEART DIS	11
V811	SCREEN FOR HYPERTENSION	11
V812	SCREEN-CARDIOVASC NEC	11
V813	SCREEN-BRONCH/EMPHYSEMA	11
V814	SCREEN-RESPIR COND NEC	11
V815	SCREEN FOR NEPHROPATHY	11
V816	SCREEN FOR GU COND NEC	11
V820	SCREEN FOR SKIN COND	11
V821	SCREEN-RHEUMATOID ARTHR	11
V822	SCREEN-RHEUMAT DIS NEC	11
V823	SCREEN-CONG HIP DISLOCAT	11
V824	POSTNAT SCREEN-CHROM ABN	11
V825	SCREEN-CONTAMINATION NEC	11
V826	MULTIPHASIC SCREENING	11
V828	SCREEN FOR CONDITION NEC	11
V829	SCREEN FOR CONDITION NOS	11

ADDENDUM G.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES

CPT [1]/ HCPCS [2]	HOPD status indicator	Description
15756	C	Free muscle flap, microvasc
15757	C	Free skin flap, microvasc
15758	C	Free fascial flap, microvasc
19200	C	Removal of breast

ADDENDUM G.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description
19220	C	Removal of breast
19240	C	Removal of breast
19260	C	Removal of chest wall lesion
19271	C	Revision of chest wall

ADDENDUM G.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description
19272	C	Extensive chest wall surgery
19361	C	Breast reconstruction
19364	C	Breast reconstruction
19367	C	Breast reconstruction

ADDENDUM G.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description
19368	C	Breast reconstruction
19369	C	Breast reconstruction
20100	C	Explore wound, neck
20101	C	Explore wound, chest
20102	C	Explore wound, abdomen
20103	C	Explore wound, extremity
20150	C	Excise epiphyseal bar
20660	C	Apply,remove fixation device
20661	C	Application of head brace
20662	C	Application of pelvis brace
20663	C	Application of thigh brace
20664	C	Halo brace application
20802	C	Replantation, arm, complete
20805	C	Replant forearm, complete
20808	C	Replantation, hand, complete
20816	C	Replantation digit, complete
20822	C	Replantation digit, complete
20824	C	Replantation thumb, complete
20827	C	Replantation thumb, complete
20838	C	Replantation, foot, complete
20930	C	Spinal bone allograft
20931	C	Spinal bone allograft
20936	C	Spinal bone autograft
20937	C	Spinal bone autograft
20938	C	Spinal bone autograft
20955	C	Fibula bone graft, microvasc
20956	C	Iliac bone graft, microvasc
20957	C	Mt bone graft, microvasc
20962	C	Other bone graft, microvasc
20969	C	Bone/skin graft, microvasc
20970	C	Bone/skin graft, iliac crest
20972	C	Bone-skin graft, metatarsal
20973	C	Bone-skin graft, great toe
21045	C	Extensive jaw surgery
21137	C	Reduction of forehead
21138	C	Reduction of forehead
21139	C	Reduction of forehead
21141	C	Reconstruct midface, lefort
21142	C	Reconstruct midface, lefort
21143	C	Reconstruct midface, lefort
21145	C	Reconstruct midface, lefort
21146	C	Reconstruct midface, lefort
21147	C	Reconstruct midface, lefort
21150	C	Reconstruct midface, lefort
21151	C	Reconstruct midface, lefort
21154	C	Reconstruct midface, lefort
21155	C	Reconstruct midface, lefort
21159	C	Reconstruct midface, lefort
21160	C	Reconstruct midface, lefort
21172	C	Reconstruct orbit/forehead
21175	C	Reconstruct orbit/forehead
21179	C	Reconstruct entire forehead
21180	C	Reconstruct entire forehead
21182	C	Reconstruct cranial bone
21183	C	Reconstruct cranial bone
21184	C	Reconstruct cranial bone
21188	C	Reconstruction of midface
21193	C	Reconstruct lower jaw bone
21194	C	Reconstruct lower jaw bone
21195	C	Reconstruct lower jaw bone
21196	C	Reconstruct lower jaw bone
21198	C	Reconstruct lower jaw bone
21247	C	Reconstruct lower jaw bone
21255	C	Reconstruct lower jaw bone
21256	C	Reconstruction of orbit
21261	C	Revise eye sockets
21263	C	Revise eye sockets
21268	C	Revise eye sockets
21344	C	Repair of sinus fracture
21346	C	Repair of nose/jaw fracture
21347	C	Repair of nose/jaw fracture
21348	C	Repair of nose/jaw fracture
21356	C	Repair cheek bone fracture

ADDENDUM G.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description
21360	C	Repair cheek bone fracture
21365	C	Repair cheek bone fracture
21366	C	Repair cheek bone fracture
21385	C	Repair eye socket fracture
21386	C	Repair eye socket fracture
21387	C	Repair eye socket fracture
21390	C	Repair eye socket fracture
21395	C	Repair eye socket fracture
21406	C	Repair eye socket fracture
21407	C	Repair eye socket fracture
21408	C	Repair eye socket fracture
21422	C	Repair mouth roof fracture
21423	C	Repair mouth roof fracture
21431	C	Treat craniofacial fracture
21432	C	Repair craniofacial fracture
21433	C	Repair craniofacial fracture
21435	C	Repair craniofacial fracture
21436	C	Repair craniofacial fracture
21470	C	Repair lower jaw fracture
21495	C	Repair hyoid bone fracture
21510	C	Drainage of bone lesion
21557	C	Remove tumor, neck or chest
21615	C	Removal of rib
21616	C	Removal of rib and nerves
21620	C	Partial removal of sternum
21627	C	Sternal debridement
21630	C	Extensive sternum surgery
21632	C	Extensive sternum surgery
21705	C	Revision of neck muscle/rib
21740	C	Reconstruction of sternum
21750	C	Repair of sternum separation
21810	C	Treatment of rib fracture(s)
21825	C	Repair sternum fracture
22100	C	Remove part of neck vertebra
22101	C	Remove part, thorax vertebra
22102	C	Remove part, lumbar vertebra
22103	C	Remove extra spine segment
22110	C	Remove part of neck vertebra
22112	C	Remove part, thorax vertebra
22114	C	Remove part, lumbar vertebra
22116	C	Remove extra spine segment
22210	C	Revision of neck spine
22212	C	Revision of thorax spine
22214	C	Revision of lumbar spine
22216	C	Revise, extra spine segment
22220	C	Revision of neck spine
22222	C	Revision of thorax spine
22224	C	Revision of lumbar spine
22226	C	Revise, extra spine segment
22325	C	Repair of spine fracture
22326	C	Repair neck spine fracture
22327	C	Repair thorax spine fracture
22328	C	Repair each add spine fx
22548	C	Neck spine fusion
22554	C	Neck spine fusion
22556	C	Thorax spine fusion
22558	C	Lumbar spine fusion
22585	C	Additional spinal fusion
22590	C	Spine & skull spinal fusion
22595	C	Neck spinal fusion
22600	C	Neck spine fusion
22610	C	Thorax spine fusion
22612	C	Lumbar spine fusion
22614	C	Spine fusion, extra segment
22630	C	Lumbar spine fusion
22632	C	Spine fusion, extra segment
22800	C	Fusion of spine
22802	C	Fusion of spine
22804	C	Fusion of spine
22808	C	Fusion of spine
22810	C	Fusion of spine
22812	C	Fusion of spine
22818	C	Kyphectomy, 1–2 segments

ADDENDUM G.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description
22819	C	Kyphectomy, 3 & more segments
22830	C	Exploration of spinal fusion
22840	C	Insert spine fixation device
22841	C	Insert spine fixation device
22842	C	Insert spine fixation device
22843	C	Insert spine fixation device
22844	C	Insert spine fixation device
22845	C	Insert spine fixation device
22846	C	Insert spine fixation device
22847	C	Insert spine fixation device
22848	C	Insert pelvic fixation device
22849	C	Reinsert spinal fixation
22850	C	Remove spine fixation device
22851	C	Apply spine prosth device
22852	C	Remove spine fixation device
22855	C	Remove spine fixation device
23035	C	Drain shoulder bone lesion
23125	C	Removal of collarbone
23195	C	Removal of head of humerus
23200	C	Removal of collar bone
23210	C	Removal of shoulderblade
23220	C	Partial removal of humerus
23221	C	Partial removal of humerus
23222	C	Partial removal of humerus
23332	C	Remove shoulder foreign body
23395	C	Muscle transfer, shoulder/arm
23397	C	Muscle transfers
23400	C	Fixation of shoulder blade
23440	C	Removal/transplant tendon
23470	C	Reconstruct shoulder joint
23472	C	Reconstruct shoulder joint
23900	C	Amputation of arm & girdle
23920	C	Amputation at shoulder joint
24149	C	Radical resection of elbow
24150	C	Extensive humerus surgery
24151	C	Extensive humerus surgery
24152	C	Extensive radius surgery
24153	C	Extensive radius surgery
24900	C	Amputation of upper arm
24920	C	Amputation of upper arm
24930	C	Amputation follow-up surgery
24931	C	Amputate upper arm & implant
24935	C	Revision of amputation
24940	C	Revision of upper arm
25170	C	Extensive forearm surgery
25390	C	Shorten radius/ulna
25391	C	Lengthen radius/ulna
25392	C	Shorten radius & ulna
25393	C	Lengthen radius & ulna
25405	C	Repair/graft radius or ulna
25420	C	Repair/graft radius & ulna
25900	C	Amputation of forearm
25905	C	Amputation of forearm
25909	C	Amputation follow-up surgery
25915	C	Amputation of forearm
25920	C	Amputate hand at wrist
25924	C	Amputation follow-up surgery
25927	C	Amputation of hand
25931	C	Amputation follow-up surgery
26551	C	Great toe-hand transfer
26553	C	Single toe-hand transfer
26554	C	Double toe-hand transfer
26556	C	Toe joint transfer
26992	C	Drainage of bone lesion
27005	C	Incision of hip tendon
27006	C	Incision of hip tendons
27025	C	Incision of hip/thigh fascia
27030	C	Drainage of hip joint
27035	C	Denervation of hip joint
27036	C	Excision of hip joint/muscle

ADDENDUM G.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description
27054	C	Removal of hip joint lining
27070	C	Partial removal of hip bone
27071	C	Partial removal of hip bone
27075	C	Extensive hip surgery
27076	C	Extensive hip surgery
27077	C	Extensive hip surgery
27078	C	Extensive hip surgery
27079	C	Extensive hip surgery
27090	C	Removal of hip prosthesis
27091	C	Removal of hip prosthesis
27120	C	Reconstruction of hip socket
27122	C	Reconstruction of hip socket
27125	C	Partial hip replacement
27130	C	Total hip replacement
27132	C	Total hip replacement
27134	C	Revise hip joint replacement
27137	C	Revise hip joint replacement
27138	C	Revise hip joint replacement
27140	C	Transplant of femur ridge
27146	C	Incision of hip bone
27147	C	Revision of hip bone
27151	C	Incision of hip bones
27156	C	Revision of hip bones
27158	C	Revision of pelvis
27161	C	Incision of neck of femur
27165	C	Incision/fixation of femur
27170	C	Repair/graft femur head/neck
27175	C	Treat slipped epiphysis
27176	C	Treat slipped epiphysis
27177	C	Repair slipped epiphysis
27178	C	Repair slipped epiphysis
27179	C	Revise head/neck of femur
27181	C	Repair slipped epiphysis
27185	C	Revision of femur epiphysis
27187	C	Reinforce hip bones
27215	C	Pelvic fracture(s) treatment
27216	C	Treat pelvic ring fracture
27217	C	Treat pelvic ring fracture
27218	C	Treat pelvic ring fracture
27222	C	Treat hip socket fracture
27226	C	Treat hip wall fracture
27227	C	Treat hip fracture(s)
27228	C	Treat hip fracture(s)
27232	C	Treat fracture of thigh
27235	C	Repair of thigh fracture
27236	C	Repair of thigh fracture
27240	C	Treatment of thigh fracture
27244	C	Repair of thigh fracture
27245	C	Repair of thigh fracture
27248	C	Repair of thigh fracture
27253	C	Repair of hip dislocation
27254	C	Repair of hip dislocation
27258	C	Repair of hip dislocation
27259	C	Repair of hip dislocation
27280	C	Fusion of sacroiliac joint
27282	C	Fusion of pubic bones
27284	C	Fusion of hip joint
27286	C	Fusion of hip joint
27290	C	Amputation of leg at hip
27295	C	Amputation of leg at hip
27303	C	Drainage of bone lesion
27365	C	Extensive leg surgery
27445	C	Revision of knee joint
27446	C	Revision of knee joint
27447	C	Total knee replacement
27448	C	Incision of thigh
27450	C	Incision of thigh
27454	C	Realignment of thigh bone
27455	C	Realignment of knee
27457	C	Realignment of knee
27465	C	Shortening of thigh bone
27466	C	Lengthening of thigh bone
27468	C	Shorten/lengthen thighs

ADDENDUM G.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description
27470	C	Repair of thigh
27472	C	Repair/graft of thigh
27475	C	Surgery to stop leg growth
27477	C	Surgery to stop leg growth
27479	C	Surgery to stop leg growth
27485	C	Surgery to stop leg growth
27486	C	Revise knee joint replace
27487	C	Revise knee joint replace
27488	C	Removal of knee prosthesis
27495	C	Reinforce thigh
27506	C	Repair of thigh fracture
27507	C	Treatment of thigh fracture
27511	C	Treatment of thigh fracture
27513	C	Treatment of thigh fracture
27514	C	Repair of thigh fracture
27519	C	Repair of thigh growth plate
27524	C	Repair of kneecap fracture
27535	C	Treatment of knee fracture
27536	C	Repair of knee fracture
27540	C	Repair of knee fracture
27557	C	Repair of knee dislocation
27558	C	Repair of knee dislocation
27580	C	Fusion of knee
27590	C	Amputate leg at thigh
27591	C	Amputate leg at thigh
27592	C	Amputate leg at thigh
27596	C	Amputation follow-up surgery
27598	C	Amputate lower leg at knee
27645	C	Extensive lower leg surgery
27646	C	Extensive lower leg surgery
27702	C	Reconstruct ankle joint
27703	C	Reconstruction, ankle joint
27712	C	Realignment of lower leg
27715	C	Revision of lower leg
27720	C	Repair of tibia
27722	C	Repair/graft of tibia
27724	C	Repair/graft of tibia
27725	C	Repair of lower leg
27727	C	Repair of lower leg
27880	C	Amputation of lower leg
27881	C	Amputation of lower leg
27882	C	Amputation of lower leg
27886	C	Amputation follow-up surgery
27888	C	Amputation of foot at ankle
28800	C	Amputation of midfoot
28805	C	Amputation thru metatarsal
31225	C	Removal of upper jaw
31230	C	Removal of upper jaw
31290	C	Nasal/sinus endoscopy, surg
31291	C	Nasal/sinus endoscopy, surg
31292	C	Nasal/sinus endoscopy, surg
31293	C	Nasal/sinus endoscopy, surg
31294	C	Nasal/sinus endoscopy, surg
31360	C	Removal of larynx
31365	C	Removal of larynx
31367	C	Partial removal of larynx
31368	C	Partial removal of larynx
31370	C	Partial removal of larynx
31375	C	Partial removal of larynx
31380	C	Partial removal of larynx
31382	C	Partial removal of larynx
31390	C	Removal of larynx & pharynx
31395	C	Reconstruct larynx & pharynx
31580	C	Revision of larynx
31582	C	Revision of larynx
31584	C	Repair of larynx fracture
31587	C	Revision of larynx
31600	C	Incision of windpipe
31601	C	Incision of windpipe
31610	C	Incision of windpipe
31725	C	Clearance of airways
31760	C	Repair of windpipe
31766	C	Reconstruction of windpipe

ADDENDUM G.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description
31770	C	Repair/graft of bronchus
31775	C	Reconstruct bronchus
31780	C	Reconstruct windpipe
31781	C	Reconstruct windpipe
31785	C	Remove windpipe lesion
31786	C	Remove windpipe lesion
31800	C	Repair of windpipe injury
31805	C	Repair of windpipe injury
32005	C	Treat lung lining chemically
32035	C	Exploration of chest
32036	C	Exploration of chest
32095	C	Biopsy through chest wall
32100	C	Exploration/biopsy of chest
32110	C	Explore/repair chest
32120	C	Re-exploration of chest
32124	C	Explore chest, free adhesions
32140	C	Removal of lung lesion(s)
32141	C	Remove/treat lung lesions
32150	C	Removal of lung lesion(s)
32151	C	Remove lung foreign body
32160	C	Open chest heart massage
32200	C	Open drainage, lung lesion
32201	C	Percut drainage, lung lesion
32215	C	Treat chest lining
32220	C	Release of lung
32225	C	Partial release of lung
32310	C	Removal of chest lining
32320	C	Free/remove chest lining
32402	C	Open biopsy chest lining
32440	C	Removal of lung
32442	C	Sleeve pneumonectomy
32445	C	Removal of lung
32480	C	Partial removal of lung
32482	C	Bilobectomy
32484	C	Segmentectomy
32486	C	Sleeve lobectomy
32488	C	Completion pneumonectomy
32491	C	Lung volume reduction
32500	C	Partial removal of lung
32501	C	Repair bronchus (add-on)
32520	C	Remove lung & revise chest
32522	C	Remove lung & revise chest
32525	C	Remove lung & revise chest
32540	C	Removal of lung lesion
32601	C	Thoracoscopy, diagnostic
32602	C	Thoracoscopy, diagnostic
32603	C	Thoracoscopy, diagnostic
32604	C	Thoracoscopy, diagnostic
32605	C	Thoracoscopy, diagnostic
32606	C	Thoracoscopy, diagnostic
32650	C	Thoracoscopy, surgical
32651	C	Thoracoscopy, surgical
32652	C	Thoracoscopy, surgical
32653	C	Thoracoscopy, surgical
32654	C	Thoracoscopy, surgical
32655	C	Thoracoscopy, surgical
32656	C	Thoracoscopy, surgical
32657	C	Thoracoscopy, surgical
32658	C	Thoracoscopy, surgical
32659	C	Thoracoscopy, surgical
32660	C	Thoracoscopy, surgical
32661	C	Thoracoscopy, surgical
32662	C	Thoracoscopy, surgical
32663	C	Thoracoscopy, surgical
32664	C	Thoracoscopy, surgical
32665	C	Thoracoscopy, surgical
32800	C	Repair lung hernia
32810	C	Close chest after drainage
32815	C	Close bronchial fistula
32820	C	Reconstruct injured chest
32850	C	Donor pneumonectomy
32851	C	Lung transplant, single
32852	C	Lung transplant w/bypass

ADDENDUM G.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description
32853	C	Lung transplant, double
32854	C	Lung transplant w/bypass
32900	C	Removal of rib(s)
32905	C	Revise & repair chest wall
32906	C	Revise & repair chest wall
32940	C	Revision of lung
33015	C	Incision of heart sac
33020	C	Incision of heart sac
33025	C	Incision of heart sac
33030	C	Partial removal of heart sac
33031	C	Partial removal of heart sac
33050	C	Removal of heart sac lesion
33120	C	Removal of heart lesion
33130	C	Removal of heart lesion
33200	C	Insertion of heart pacemaker
33201	C	Insertion of heart pacemaker
33206	C	Insertion of heart pacemaker
33207	C	Insertion of heart pacemaker
33208	C	Insertion of heart pacemaker
33210	C	Insertion of heart electrode
33211	C	Insertion of heart electrode
33212	C	Insertion of pulse generator
33213	C	Insertion of pulse generator
33214	C	Upgrade of pacemaker system
33216	C	Revision implanted electrode
33217	C	Insert/revise electrode
33218	C	Repair pacemaker electrodes
33220	C	Repair pacemaker electrode
33233	C	Removal of pacemaker system
33234	C	Removal of pacemaker system
33235	C	Removal pacemaker electrode
33236	C	Remove electrode/ thoracotomy
33237	C	Remove electrode/ thoracotomy
33238	C	Remove electrode/ thoracotomy
33240	C	Insert/replace pulse gener
33241	C	Remove pulse generator only
33242	C	Repair pulse generator/leads
33243	C	Remove generator/ thoracotomy
33244	C	Remove generator
33245	C	Implant heart defibrillator
33246	C	Implant heart defibrillator
33247	C	Insert/replace leads
33249	C	Insert/replace leads/gener
33250	C	Ablate heart dysrhythm focus
33251	C	Ablate heart dysrhythm focus
33253	C	Reconstruct atria
33261	C	Ablate heart dysrhythm focus
33300	C	Repair of heart wound
33305	C	Repair of heart wound
33310	C	Exploratory heart surgery
33315	C	Exploratory heart surgery
33320	C	Repair major blood vessel(s)
33321	C	Repair major vessel
33322	C	Repair major blood vessel(s)
33330	C	Insert major vessel graft
33332	C	Insert major vessel graft
33335	C	Insert major vessel graft
33400	C	Repair of aortic valve
33401	C	Valvuloplasty, open
33403	C	Valvuloplasty, w/cp bypass
33404	C	Prepare heart-aorta conduit
33405	C	Replacement of aortic valve
33406	C	Replacement, aortic valve
33411	C	Replacement of aortic valve
33412	C	Replacement of aortic valve
33413	C	Replacement, aortic valve

ADDENDUM G.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description
33414	C	Repair, aortic valve
33415	C	Revision, subvalvular tissue
33416	C	Revise ventricle muscle
33417	C	Repair of aortic valve
33420	C	Revision of mitral valve
33422	C	Revision of mitral valve
33425	C	Repair of mitral valve
33426	C	Repair of mitral valve
33427	C	Repair of mitral valve
33430	C	Replacement of mitral valve
33460	C	Revision of tricuspid valve
33463	C	Valvuloplasty, tricuspid
33464	C	Valvuloplasty, tricuspid
33465	C	Replace tricuspid valve
33468	C	Revision of tricuspid valve
33470	C	Revision of pulmonary valve
33471	C	Valvotomy, pulmonary valve
33472	C	Revision of pulmonary valve
33474	C	Revision of pulmonary valve
33475	C	Replacement, pulmonary valve
33476	C	Revision of heart chamber
33478	C	Revision of heart chamber
33496	C	Repair, prosth valve clot
33500	C	Repair heart vessel fistula
33501	C	Repair heart vessel fistula
33502	C	Coronary artery correction
33503	C	Coronary artery graft
33504	C	Coronary artery graft
33505	C	Repair artery w/tunnel
33506	C	Repair artery, translocation
33510	C	CABG, vein, single
33511	C	CABG, vein, two
33512	C	CABG, vein, three
33513	C	CABG, vein, four
33514	C	CABG, vein, five
33516	C	CABG, vein, six+
33517	C	CABG, artery-vein, single
33518	C	CABG, artery-vein, two
33519	C	CABG, artery-vein, three
33521	C	CABG, artery-vein, four
33522	C	CABG, artery-vein, five
33523	C	CABG, artery-vein, six+
33530	C	Coronary artery, bypass/reop
33533	C	CABG, arterial, single
33534	C	CABG, arterial, two
33535	C	CABG, arterial, three
33536	C	CABG, arterial, four+
33542	C	Removal of heart lesion
33545	C	Repair of heart damage
33572	C	Open coronary endarterectomy
33600	C	Closure of valve
33602	C	Closure of valve
33606	C	Anastomosis/artery-aorta
33608	C	Repair anomaly w/conduit
33610	C	Repair by enlargement
33611	C	Repair double ventricle
33612	C	Repair double ventricle
33615	C	Repair (simple fontan)
33617	C	Repair by modified fontan
33619	C	Repair single ventricle
33641	C	Repair heart septum defect
33645	C	Revision of heart veins
33647	C	Repair heart septum defects
33660	C	Repair of heart defects
33665	C	Repair of heart defects
33670	C	Repair of heart chambers
33681	C	Repair heart septum defect
33684	C	Repair heart septum defect
33688	C	Repair heart septum defect
33690	C	Reinforce pulmonary artery
33692	C	Repair of heart defects

ADDENDUM G.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description
33694	C	Repair of heart defects
33697	C	Repair of heart defects
33702	C	Repair of heart defects
33710	C	Repair of heart defects
33720	C	Repair of heart defect
33722	C	Repair of heart defect
33730	C	Repair heart-vein defect(s)
33732	C	Repair heart-vein defect
33735	C	Revision of heart chamber
33736	C	Revision of heart chamber
33737	C	Revision of heart chamber
33750	C	Major vessel shunt
33755	C	Major vessel shunt
33762	C	Major vessel shunt
33764	C	Major vessel shunt & graft
33766	C	Major vessel shunt
33767	C	Atrial septectomy/septostomy
33770	C	Repair great vessels defect
33771	C	Repair great vessels defect
33774	C	Repair great vessels defect
33775	C	Repair great vessels defect
33776	C	Repair great vessels defect
33777	C	Repair great vessels defect
33778	C	Repair great vessels defect
33779	C	Repair great vessels defect
33780	C	Repair great vessels defect
33781	C	Repair great vessels defect
33786	C	Repair arterial trunk
33788	C	Revision of pulmonary artery
33800	C	Aortic suspension
33802	C	Repair vessel defect
33803	C	Repair vessel defect
33813	C	Repair septal defect
33814	C	Repair septal defect
33820	C	Revise major vessel
33822	C	Revise major vessel
33824	C	Revise major vessel
33840	C	Remove aorta constriction
33845	C	Remove aorta constriction
33851	C	Remove aorta constriction
33852	C	Repair septal defect
33853	C	Repair septal defect
33860	C	Ascending aorta graft
33861	C	Ascending aorta graft
33863	C	Ascending aorta graft
33870	C	Transverse aortic arch graft
33875	C	Thoracic aorta graft
33877	C	Thoracoabdominal graft
33910	C	Remove lung artery emboli
33915	C	Remove lung artery emboli
33916	C	Surgery of great vessel
33917	C	Repair pulmonary artery
33918	C	Repair pulmonary atresia
33919	C	Repair pulmonary atresia
33920	C	Repair pulmonary atresia
33922	C	Transect pulmonary artery
33924	C	Remove pulmonary shunt
33930	C	Removal of donor heart/lung
33935	C	Transplantation, heart/lung
33940	C	Removal of donor heart
33945	C	Transplantation of heart
33960	C	External circulation assist
33961	C	External circulation assist
33970	C	Aortic circulation assist
33971	C	Aortic circulation assist
33973	C	Insert balloon device
33974	C	Remove intra-aortic balloon
33975	C	Implant ventricular device
33976	C	Implant ventricular device
33977	C	Remove ventricular device
33978	C	Remove ventricular device
34001	C	Removal of artery clot
34051	C	Removal of artery clot

ADDENDUM G.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description
34101	C	Removal of artery clot
34111	C	Removal of arm artery clot
34151	C	Removal of artery clot
34201	C	Removal of artery clot
34203	C	Removal of leg artery clot
34401	C	Removal of vein clot
34421	C	Removal of vein clot
34451	C	Removal of vein clot
34471	C	Removal of vein clot
34490	C	Removal of vein clot
34501	C	Repair valve, femoral vein
34502	C	Reconstruct, vena cava
34510	C	Transposition of vein valve
34520	C	Cross-over vein graft
34530	C	Leg vein fusion
35001	C	Repair defect of artery
35002	C	Repair artery rupture, neck
35005	C	Repair defect of artery
35011	C	Repair defect of artery
35013	C	Repair artery rupture, arm
35021	C	Repair defect of artery
35022	C	Repair artery rupture, chest
35045	C	Repair defect of arm artery
35081	C	Repair defect of artery
35082	C	Repair artery rupture, aorta
35091	C	Repair defect of artery
35092	C	Repair artery rupture, aorta
35102	C	Repair defect of artery
35103	C	Repair artery rupture, groin
35111	C	Repair defect of artery
35112	C	Repair artery rupture,spleen
35121	C	Repair defect of artery
35122	C	Repair artery rupture, belly
35131	C	Repair defect of artery
35132	C	Repair artery rupture, groin
35141	C	Repair defect of artery
35142	C	Repair artery rupture, thigh
35151	C	Repair defect of artery
35152	C	Repair artery rupture, knee
35161	C	Repair defect of artery
35162	C	Repair artery rupture
35180	C	Repair blood vessel lesion
35182	C	Repair blood vessel lesion
35184	C	Repair blood vessel lesion
35189	C	Repair blood vessel lesion
35190	C	Repair blood vessel lesion
35201	C	Repair blood vessel lesion
35206	C	Repair blood vessel lesion
35211	C	Repair blood vessel lesion
35216	C	Repair blood vessel lesion
35221	C	Repair blood vessel lesion
35226	C	Repair blood vessel lesion
35231	C	Repair blood vessel lesion
35236	C	Repair blood vessel lesion
35241	C	Repair blood vessel lesion
35246	C	Repair blood vessel lesion
35251	C	Repair blood vessel lesion
35256	C	Repair blood vessel lesion
35261	C	Repair blood vessel lesion
35266	C	Repair blood vessel lesion
35271	C	Repair blood vessel lesion
35276	C	Repair blood vessel lesion
35281	C	Repair blood vessel lesion
35286	C	Repair blood vessel lesion
35301	C	Rechanneling of artery
35311	C	Rechanneling of artery
35321	C	Rechanneling of artery
35331	C	Rechanneling of artery
35341	C	Rechanneling of artery
35351	C	Rechanneling of artery
35355	C	Rechanneling of artery
35361	C	Rechanneling of artery
35363	C	Rechanneling of artery

ADDENDUM G.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description
35371	C	Rechanneling of artery
35372	C	Rechanneling of artery
35381	C	Rechanneling of artery
35390	C	Reoperation, carotid
35400	C	Angioscopy
35450	C	Repair arterial blockage
35452	C	Repair arterial blockage
35454	C	Repair arterial blockage
35456	C	Repair arterial blockage
35458	C	Repair arterial blockage
35459	C	Repair arterial blockage
35460	C	Repair venous blockage
35470	C	Repair arterial blockage
35471	C	Repair arterial blockage
35472	C	Repair arterial blockage
35473	C	Repair arterial blockage
35474	C	Repair arterial blockage
35475	C	Repair arterial blockage
35476	C	Repair venous blockage
35480	C	Atherectomy, open
35481	C	Atherectomy, open
35482	C	Atherectomy, open
35483	C	Atherectomy, open
35484	C	Atherectomy, open
35485	C	Atherectomy, open
35490	C	Atherectomy, percutaneous
35491	C	Atherectomy, percutaneous
35492	C	Atherectomy, percutaneous
35493	C	Atherectomy, percutaneous
35494	C	Atherectomy, percutaneous
35495	C	Atherectomy, percutaneous
35501	C	Artery bypass graft
35506	C	Artery bypass graft
35507	C	Artery bypass graft
35508	C	Artery bypass graft
35509	C	Artery bypass graft
35511	C	Artery bypass graft
35515	C	Artery bypass graft
35516	C	Artery bypass graft
35518	C	Artery bypass graft
35521	C	Artery bypass graft
35526	C	Artery bypass graft
35531	C	Artery bypass graft
35533	C	Artery bypass graft
35536	C	Artery bypass graft
35541	C	Artery bypass graft
35546	C	Artery bypass graft
35548	C	Artery bypass graft
35549	C	Artery bypass graft
35551	C	Artery bypass graft
35556	C	Artery bypass graft
35558	C	Artery bypass graft
35560	C	Artery bypass graft
35563	C	Artery bypass graft
35565	C	Artery bypass graft
35566	C	Artery bypass graft
35571	C	Artery bypass graft
35582	C	Vein bypass graft
35583	C	Vein bypass graft
35585	C	Vein bypass graft
35587	C	Vein bypass graft
35601	C	Artery bypass graft
35606	C	Artery bypass graft
35612	C	Artery bypass graft
35616	C	Artery bypass graft
35621	C	Artery bypass graft
35623	C	Bypass graft, not vein
35626	C	Artery bypass graft
35631	C	Artery bypass graft
35636	C	Artery bypass graft
35641	C	Artery bypass graft
35642	C	Artery bypass graft
35645	C	Artery bypass graft

ADDENDUM G.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description
35646	C	Artery bypass graft
35650	C	Artery bypass graft
35651	C	Artery bypass graft
35654	C	Artery bypass graft
35656	C	Artery bypass graft
35661	C	Artery bypass graft
35663	C	Artery bypass graft
35665	C	Artery bypass graft
35666	C	Artery bypass graft
35671	C	Artery bypass graft
35681	C	Artery bypass graft
35691	C	Arterial transposition
35693	C	Arterial transposition
35694	C	Arterial transposition
35695	C	Arterial transposition
35700	C	Reoperation, bypass graft
35701	C	Exploration, carotid artery
35721	C	Exploration, femoral artery
35741	C	Exploration popliteal artery
35761	C	Exploration of artery/vein
35800	C	Explore neck vessels
35820	C	Explore chest vessels
35840	C	Explore abdominal vessels
35860	C	Explore limb vessels
35870	C	Repair vessel graft defect
35901	C	Excision, graft, neck
35903	C	Excision, graft, extremity
35905	C	Excision, graft, thorax
35907	C	Excision, graft, abdomen
36510	C	Insertion of catheter, vein
36660	C	Insertion catheter, artery
36822	C	Insertion of cannula(s)
36834	C	Repair A-V aneurysm
37140	C	Revision of circulation
37145	C	Revision of circulation
37160	C	Revision of circulation
37180	C	Revision of circulation
37181	C	Splice spleen/kidney veins
37195	C	Thrombolytic therapy, stroke
37200	C	Transcatheter biopsy
37201	C	Transcatheter therapy infuse
37202	C	Transcatheter therapy infuse
37204	C	Transcatheter occlusion
37205	C	Transcatheter stent
37206	C	Transcatheter stent
37207	C	Transcatheter stent
37208	C	Transcatheter stent
37209	C	Exchange arterial catheter
37250	C	Intravascular us
37251	C	Intravascular us
37565	C	Ligation of neck vein
37600	C	Ligation of neck artery
37605	C	Ligation of neck artery
37606	C	Ligation of neck artery
37615	C	Ligation of neck artery
37616	C	Ligation of chest artery
37617	C	Ligation of abdomen artery
37620	C	Revision of major vein
37660	C	Revision of major vein
37788	C	Revascularization, penis
38100	C	Removal of spleen, total
38101	C	Removal of spleen, partial
38102	C	Removal of spleen, total
38115	C	Repair of ruptured spleen
38240	C	Bone marrow/stem transplant
38241	C	Bone marrow/stem transplant
38380	C	Thoracic duct procedure
38381	C	Thoracic duct procedure
38382	C	Thoracic duct procedure
38562	C	Removal, pelvic lymph nodes
38564	C	Removal, abdomen lymph nodes
38700	C	Removal of lymph nodes, neck

ADDENDUM G.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description
38720	C	Removal of lymph nodes, neck
38724	C	Removal of lymph nodes, neck
38746	C	Remove thoracic lymph nodes
38747	C	Remove abdominal lymph nodes
38765	C	Remove groin lymph nodes
38770	C	Remove pelvis lymph nodes
38780	C	Remove abdomen lymph nodes
39000	C	Exploration of chest
39010	C	Exploration of chest
39200	C	Removal chest lesion
39220	C	Removal chest lesion
39400	C	Visualization of chest
39499	C	Chest procedure
39501	C	Repair diaphragm laceration
39502	C	Repair paraesophageal hernia
39503	C	Repair of diaphragm hernia
39520	C	Repair of diaphragm hernia
39530	C	Repair of diaphragm hernia
39531	C	Repair of diaphragm hernia
39540	C	Repair of diaphragm hernia
39541	C	Repair of diaphragm hernia
39545	C	Revision of diaphragm
39599	C	Diaphragm surgery procedure
41130	C	Partial removal of tongue
41135	C	Tongue and neck surgery
41140	C	Removal of tongue
41145	C	Tongue removal; neck surgery
41150	C	Tongue, mouth, jaw surgery
41153	C	Tongue, mouth, neck surgery
41155	C	Tongue, jaw, & neck surgery
42145	C	Repair, palate,pharynx/uvula
42426	C	Excise parotid gland/lesion
42845	C	Extensive surgery of throat
42894	C	Revision of pharyngeal walls
42953	C	Repair throat, esophagus
42961	C	Control throat bleeding
42971	C	Control nose/throat bleeding
43045	C	Incision of esophagus
43100	C	Excision of esophagus lesion
43101	C	Excision of esophagus lesion
43107	C	Removal of esophagus
43108	C	Removal of esophagus
43112	C	Removal of esophagus
43113	C	Removal of esophagus
43116	C	Partial removal of esophagus
43117	C	Partial removal of esophagus
43118	C	Partial removal of esophagus
43121	C	Partial removal of esophagus
43122	C	Parital removal of esophagus
43123	C	Partial removal of esophagus
43124	C	Removal of esophagus
43130	C	Removal of esophagus pouch
43135	C	Removal of esophagus pouch
43300	C	Repair of esophagus
43305	C	Repair esophagus and fistula
43310	C	Repair of esophagus
43312	C	Repair esophagus and fistula
43320	C	Fuse esophagus & stomach
43324	C	Revise esophagus & stomach
43325	C	Revise esophagus & stomach
43326	C	Revise esophagus & stomach
43330	C	Repair of esophagus
43331	C	Repair of esophagus
43340	C	Fuse esophagus & intestine
43341	C	Fuse esophagus & intestine
43350	C	Surgical opening, esophagus
43351	C	Surgical opening, esophagus
43352	C	Surgical opening, esophagus
43360	C	Gastrointestinal repair

ADDENDUM G.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description
43361	C	Gastrointestinal repair
43400	C	Ligate esophagus veins
43401	C	Esophagus surgery for veins
43405	C	Ligate/staple esophagus
43410	C	Repair esophagus wound
43415	C	Repair esophagus wound
43420	C	Repair esophagus opening
43425	C	Repair esophagus opening
43460	C	Pressure treatment esophagus
43496	C	Free jejunum flap, microvasc
43500	C	Surgical opening of stomach
43501	C	Surgical repair of stomach
43502	C	Surgical repair of stomach
43510	C	Surgical opening of stomach
43520	C	Incision of pyloric muscle
43605	C	Biopsy of stomach
43610	C	Excision of stomach lesion
43611	C	Excision of stomach lesion
43620	C	Removal of stomach
43621	C	Removal of stomach
43622	C	Removal of stomach
43631	C	Removal of stomach, partial
43632	C	Removal stomach, partial
43633	C	Removal stomach, partial
43634	C	Removal stomach, partial
43635	C	Partial removal of stomach
43638	C	Partial removal of stomach
43639	C	Removal stomach, partial
43640	C	Vagotomy & pylorus repair
43641	C	Vagotomy & pylorus repair
43800	C	Reconstruction of pylorus
43810	C	Fusion of stomach and bowel
43820	C	Fusion of stomach and bowel
43825	C	Fusion of stomach and bowel
43830	C	Place gastrostomy tube
43831	C	Place gastrostomy tube
43832	C	Place gastrostomy tube
43840	C	Repair of stomach lesion
43842	C	Gastroplasty for obesity
43843	C	Gastroplasty for obesity
43846	C	Gastric bypass for obesity
43847	C	Gastric bypass for obesity
43848	C	Revision gastroplasty
43850	C	Revise stomach-bowel fusion
43855	C	Revise stomach-bowel fusion
43860	C	Revise stomach-bowel fusion
43865	C	Revise stomach-bowel fusion
43880	C	Repair stomach-bowel fistula
44005	C	Freeing of bowel adhesion
44010	C	Incision of small bowel
44015	C	Insert needle catheter,bowel
44020	C	Exploration of small bowel
44021	C	Decompress small bowel
44025	C	Incision of large bowel
44050	C	Reduce bowel obstruction
44055	C	Correct malrotation of bowel
44110	C	Excision of bowel lesion(s)
44111	C	Excision of bowel lesion(s)
44120	C	Removal of small intestine
44121	C	Removal of small intestine
44125	C	Removal of small intestine
44130	C	Bowel to bowel fusion
44139	C	Mobilization of colon
44140	C	Partial removal of colon
44141	C	Partial removal of colon
44143	C	Partial removal of colon
44144	C	Partial removal of colon
44145	C	Partial removal of colon
44146	C	Partial removal of colon
44147	C	Partial removal of colon
44150	C	Removal of colon
44151	C	Removal of colon/ileostomy

ADDENDUM G.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description
44152	C	Removal of colon/ileostomy
44153	C	Removal of colon/ileostomy
44155	C	Removal of colon
44156	C	Removal of colon/ileostomy
44160	C	Removal of colon
44300	C	Open bowel to skin
44310	C	Ileostomy/jejunostomy
44314	C	Revision of ileostomy
44316	C	Devise bowel pouch
44320	C	Colostomy
44322	C	Colostomy with biopsies
44345	C	Revision of colostomy
44346	C	Revision of colostomy
44500	C	Intro, gastrointestinal tube
44602	C	Suture, small intestine
44603	C	Suture, small intestine
44604	C	Suture, large intestine
44605	C	Repair of bowel lesion
44615	C	Intestinal stricturoplasty
44620	C	Repair bowel opening
44625	C	Repair bowel opening
44626	C	Repair bowel opening
44640	C	Repair bowel-skin fistula
44650	C	Repair bowel fistula
44660	C	Repair bowel-bladder fistula
44661	C	Repair bowel-bladder fistula
44680	C	Surgical revision, intestine
44700	C	Suspend bowel w/prosthesis
44800	C	Excision of bowel pouch
44820	C	Excision of mesentery lesion
44850	C	Repair of mesentery
44899	C	Bowel surgery procedure
44900	C	Drain, app abscess, open
44901	C	Drain, app abscess, perc
44950	C	Appendectomy
44955	C	Appendectomy
44960	C	Appendectomy
45110	C	Removal of rectum
45111	C	Partial removal of rectum
45112	C	Removal of rectum
45113	C	Partial proctectomy
45114	C	Partial removal of rectum
45116	C	Partial removal of rectum
45119	C	Remove, rectum w/reservoir
45120	C	Removal of rectum
45121	C	Removal of rectum and colon
45123	C	Partial proctectomy
45130	C	Excision of rectal prolapse
45135	C	Excision of rectal prolapse
45540	C	Correct rectal prolapse
45541	C	Correct rectal prolapse
45550	C	Repair rectum; remove sigmoid
45562	C	Exploration/repair of rectum
45563	C	Exploration/repair of rectum
45800	C	Repair rectumbladder fistula
45805	C	Repair fistula; colostomy
45820	C	Repair rectourethral fistula
45825	C	Repair fistula; colostomy
46705	C	Repair of anal stricture
46715	C	Repair of anovaginal fistula
46716	C	Repair of anovaginal fistula
46730	C	Construction of absent anus
46735	C	Construction of absent anus
46740	C	Construction of absent anus
46742	C	Repair, imperforated anus
46744	C	Repair, cloacal anomaly
46746	C	Repair, cloacal anomaly
46748	C	Repair, cloacal anomaly
46751	C	Repair of anal sphincter
47001	C	Needle biopsy, liver
47010	C	Open drainage, liver lesion
47011	C	Percut drain, liver lesion

ADDENDUM G.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description
47015	C	Inject/aspirate liver cyst
47100	C	Wedge biopsy of liver
47120	C	Partial removal of liver
47122	C	Extensive removal of liver
47125	C	Partial removal of liver
47130	C	Partial removal of liver
47133	C	Removal of donor liver
47134	C	Partial removal, donor liver
47135	C	Transplantation of liver
47136	C	Transplantation of liver
47300	C	Surgery for liver lesion
47350	C	Repair liver wound
47360	C	Repair liver wound
47361	C	Repair liver wound
47362	C	Repair liver wound
47400	C	Incision of liver duct
47420	C	Incision of bile duct
47425	C	Incision of bile duct
47460	C	Incise bile duct sphincter
47480	C	Incision of gallbladder
47490	C	Incision of gallbladder
47550	C	Bile duct endoscopy
47600	C	Removal of gallbladder
47605	C	Removal of gallbladder
47610	C	Removal of gallbladder
47612	C	Removal of gallbladder
47620	C	Removal of gallbladder
47700	C	Exploration of bile ducts
47701	C	Bile duct revision
47711	C	Excision of bile duct tumor
47712	C	Excision of bile duct tumor
47715	C	Excision of bile duct cyst
47716	C	Fusion of bile duct cyst
47720	C	Fuse gallbladder & bowel
47721	C	Fuse upper gi structures
47740	C	Fuse gallbladder & bowel
47741	C	Fuse gallbladder & bowel
47760	C	Fuse bile ducts and bowel
47765	C	Fuse liver ducts & bowel
47780	C	Fuse bile ducts and bowel
47785	C	Fuse bile ducts and bowel
47800	C	Reconstruction of bile ducts
47801	C	Placement, bile duct support
47802	C	Fuse liver duct & intestine
47900	C	Suture bile duct injury
48000	C	Drainage of abdomen
48001	C	Placement of drain, pancreas
48005	C	Resect/debride pancreas
48020	C	Removal of pancreatic stone
48100	C	Biopsy of pancreas
48120	C	Removal of pancreas lesion
48140	C	Partial removal of pancreas
48145	C	Partial removal of pancreas
48146	C	Pancreatectomy
48148	C	Removal of pancreatic duct
48150	C	Partial removal of pancreas
48152	C	Pancreatectomy
48153	C	Pancreatectomy
48154	C	Pancreatectomy
48155	C	Removal of pancreas
48180	C	Fuse pancreas and bowel
48400	C	Injection, intraoperative
48500	C	Surgery of pancreas cyst
48510	C	Drain pancreatic pseudocyst
48511	C	Drain pancreatic pseudocyst
48520	C	Fuse pancreas cyst and bowel
48540	C	Fuse pancreas cyst and bowel
48545	C	Pancreatorrhaphy
48547	C	Duodenal exclusion
48556	C	Removal, allograft pancreas
49000	C	Exploration of abdomen
49002	C	Reopening of abdomen
49010	C	Exploration behind abdomen

ADDENDUM G.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description
49020	C	Drain abdominal abscess
49021	C	Drain abdominal abscess
49040	C	Open drainage abdom abscess
49041	C	Percut drain abdom abscess
49060	C	Open drain retroper abscess
49061	C	Percutdrain retroper abscess
49062	C	Drain to peritoneal cavity
49200	C	Removal of abdominal lesion
49201	C	Removal of abdominal lesion
49215	C	Excise sacral spine tumor
49220	C	Multiple surgery, abdomen
49255	C	Removal of omentum
49425	C	Insert abdomen-venous drain
49428	C	Ligation of shunt
49605	C	Repair umbilical lesion
49606	C	Repair umbilical lesion
49610	C	Repair umbilical lesion
49611	C	Repair umbilical lesion
49900	C	Repair of abdominal wall
49905	C	Omental flap
49906	C	Free omental flap, microvasc
50010	C	Exploration of kidney
50020	C	Open drain renal abscess
50021	C	Percut drain renal abscess
50040	C	Drainage of kidney
50045	C	Exploration of kidney
50060	C	Removal of kidney stone
50065	C	Incision of kidney
50070	C	Incision of kidney
50075	C	Removal of kidney stone
50080	C	Removal of kidney stone
50081	C	Removal of kidney stone
50100	C	Revise kidney blood vessels
50120	C	Exploration of kidney
50125	C	Explore and drain kidney
50130	C	Removal of kidney stone
50135	C	Exploration of kidney
50205	C	Biopsy of kidney
50220	C	Removal of kidney
50225	C	Removal of kidney
50230	C	Removal of kidney
50234	C	Removal of kidney & ureter
50236	C	Removal of kidney & ureter
50240	C	Partial removal of kidney
50280	C	Removal of kidney lesion
50290	C	Removal of kidney lesion
50300	C	Removal of donor kidney
50320	C	Removal of donor kidney
50340	C	Removal of kidney
50360	C	Transplantation of kidney
50365	C	Transplantation of kidney
50370	C	Remove transplanted kidney
50380	C	Reimplantation of kidney
50400	C	Revision of kidney/ureter
50405	C	Revision of kidney/ureter
50500	C	Repair of kidney wound
50520	C	Close kidney-skin fistula
50525	C	Repair renal-abdomen fistula
50526	C	Repair renal-abdomen fistula
50540	C	Revision of horseshoe kidney
50570	C	Kidney endoscopy
50572	C	Kidney endoscopy
50574	C	Kidney endoscopy & biopsy
50575	C	Kidney endoscopy
50576	C	Kidney endoscopy & treatment
50578	C	Renal endoscopy; radiotracer
50580	C	Kidney endoscopy & treatment
50600	C	Exploration of ureter
50605	C	Insert ureteral support
50610	C	Removal of ureter stone

ADDENDUM G.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description
50620	C	Removal of ureter stone
50630	C	Removal of ureter stone
50650	C	Removal of ureter
50660	C	Removal of ureter
50700	C	Revision of ureter
50715	C	Release of ureter
50722	C	Release of ureter
50725	C	Release/revise ureter
50727	C	Revise ureter
50728	C	Revise ureter
50740	C	Fusion of ureter & kidney
50750	C	Fusion of ureter & kidney
50760	C	Fusion of ureters
50770	C	Splicing of ureters
50780	C	Reimplant ureter in bladder
50782	C	Reimplant ureter in bladder
50783	C	Reimplant ureter in bladder
50785	C	Reimplant ureter in bladder
50800	C	Implant ureter in bowel
50810	C	Fusion of ureter & bowel
50815	C	Urine shunt to bowel
50820	C	Construct bowel bladder
50825	C	Construct bowel bladder
50830	C	Revise urine flow
50840	C	Replace ureter by bowel
50845	C	Appendico-vesicostomy
50860	C	Transplant ureter to skin
50900	C	Repair of ureter
50920	C	Closure ureter/skin fistula
50930	C	Closure ureter/bowel fistula
50940	C	Release of ureter
50970	C	Ureter endoscopy
50972	C	Ureter endoscopy & catheter
50974	C	Ureter endoscopy & biopsy
50976	C	Ureter endoscopy & treatment
50978	C	Ureter endoscopy & tracer
50980	C	Ureter endoscopy & treatment
51060	C	Removal of ureter stone
51525	C	Removal of bladder lesion
51530	C	Removal of bladder lesion
51535	C	Repair of ureter lesion
51550	C	Partial removal of bladder
51555	C	Partial removal of bladder
51565	C	Revise bladder & ureter(s)
51570	C	Removal of bladder
51575	C	Removal of bladder & nodes
51580	C	Remove bladder; revise tract
51585	C	Removal of bladder & nodes
51590	C	Remove bladder; revise tract
51595	C	Remove bladder; revise tract
51596	C	Remove bladder, create pouch
51597	C	Removal of pelvic structures
51800	C	Revision of bladder/urethra
51820	C	Revision of urinary tract
51840	C	Attach bladder/urethra
51841	C	Attach bladder/urethra
51845	C	Repair bladder neck
51860	C	Repair of bladder wound
51865	C	Repair of bladder wound
51900	C	Repair bladder/vagina lesion
51920	C	Close bladder-uterus fistula
51925	C	Hysterectomy/bladder repair
51940	C	Correction of bladder defect
51960	C	Revision of bladder & bowel
51980	C	Construct bladder opening
53085	C	Drainage of urinary leakage
53415	C	Reconstruction of urethra
53443	C	Reconstruction of urethra
54125	C	Removal of penis
54130	C	Remove penis & nodes
54135	C	Remove penis & nodes
54332	C	Revise penis, urethra

ADDENDUM G.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description
54336	C	Revise penis, urethra
54390	C	Repair penis and bladder
54430	C	Revision of penis
54535	C	Extensive testis surgery
54560	C	Exploration for testis
54650	C	Orchiopexy (Fowler-Stephens)
55600	C	Incise sperm duct pouch
55605	C	Incise sperm duct pouch
55650	C	Remove sperm duct pouch
55801	C	Removal of prostate
55810	C	Extensive prostate surgery
55812	C	Extensive prostate surgery
55815	C	Extensive prostate surgery
55821	C	Removal of prostate
55831	C	Removal of prostate
55840	C	Extensive prostate surgery
55842	C	Extensive prostate surgery
55845	C	Extensive prostate surgery
55860	C	Surgical exposure, prostate
55862	C	Extensive prostate surgery
55865	C	Extensive prostate surgery
56308	C	Laparoscopy; hysterectomy
56310	C	Laparoscopic enterolysis
56314	C	Lapar; drain lymphocele
56315	C	Laparoscopic appendectomy
56322	C	Laparoscopy, vagus nerves
56323	C	Laparoscopy, vagus nerves
56324	C	Laparoscopy, cholecystoenter
56340	C	Laparoscopic cholecystectomy
56341	C	Laparoscopic cholecystectomy
56342	C	Laparoscopic cholecystectomy
56345	C	Laparoscopic splenectomy
56347	C	Laparoscopic jejunostomy
56348	C	Laparo; resect intestine
56349	C	Laparoscopy; fundoplasty
56630	C	Extensive vulva surgery
56631	C	Extensive vulva surgery
56632	C	Extensive vulva surgery
56633	C	Extensive vulva surgery
56634	C	Extensive vulva surgery
56637	C	Extensive vulva surgery
56640	C	Extensive vulva surgery
56805	C	Repair clitoris
57108	C	Partial removal of vagina
57110	C	Removal of vagina
57120	C	Closure of vagina
57270	C	Repair of bowel pouch
57280	C	Suspension of vagina
57282	C	Repair of vaginal prolapse
57292	C	Construct vagina with graft
57305	C	Repair rectum-vagina fistula
57307	C	Fistula repair & colostomy
57308	C	Fistula repair, transperine
57310	C	Repair urethrovaginal lesion
57311	C	Repair urethrovaginal lesion
57320	C	Repair bladder-vagina lesion
57330	C	Repair bladder-vagina lesion
57335	C	Repair vagina
57531	C	Removal of cervix, radical
57540	C	Removal of residual cervix
57545	C	Remove cervix, repair pelvis
58140	C	Removal of uterus lesion
58150	C	Total hysterectomy
58152	C	Total hysterectomy
58180	C	Partial hysterectomy
58200	C	Extensive hysterectomy
58210	C	Extensive hysterectomy
58240	C	Removal of pelvis contents
58260	C	Vaginal hysterectomy
58262	C	Vaginal hysterectomy
58263	C	Vaginal hysterectomy
58267	C	Hysterectomy & vagina repair
58270	C	Hysterectomy & vagina repair

ADDENDUM G.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description
58275	C	Hysterectomy, revise vagina
58280	C	Hysterectomy, revise vagina
58285	C	Extensive hysterectomy
58400	C	Suspension of uterus
58410	C	Suspension of uterus
58520	C	Repair of ruptured uterus
58540	C	Revision of uterus
58600	C	Division of fallopian tube
58605	C	Division of fallopian tube
58611	C	Ligate oviduct(s)
58615	C	Occlude fallopian tube(s)
58700	C	Removal of fallopian tube
58720	C	Removal of ovary/tube(s)
58740	C	Revise fallopian tube(s)
58750	C	Repair oviduct
58752	C	Revise ovarian tube(s)
58760	C	Remove tubal obstruction
58770	C	Create new tubal opening
58805	C	Drainage of ovarian cyst(s)
58822	C	Percut drain ovary abscess
58823	C	Percut drain pelvic abscess
58825	C	Transposition, ovary(s)
58900	C	Biopsy of ovary(s)
58920	C	Partial removal of ovary(s)
58925	C	Removal of ovarian cyst(s)
58940	C	Removal of ovary(s)
58943	C	Removal of ovary(s)
58950	C	Resect ovarian malignancy
58951	C	Resect ovarian malignancy
58952	C	Resect ovarian malignancy
58960	C	Exploration of abdomen
59100	C	Remove uterus lesion
59120	C	Treat ectopic pregnancy
59121	C	Treat ectopic pregnancy
59130	C	Treat ectopic pregnancy
59135	C	Treat ectopic pregnancy
59136	C	Treat ectopic pregnancy
59140	C	Treat ectopic pregnancy
59150	C	Treat ectopic pregnancy
59151	C	Treat ectopic pregnancy
59325	C	Revision of cervix
59350	C	Repair of uterus
59514	C	Cesarean delivery only
59525	C	Remove uterus after cesarean
59620	C	Attempted vbac delivery only
59830	C	Treat uterus infection
59850	C	Abortion
59851	C	Abortion
59852	C	Abortion
59855	C	Abortion
59856	C	Abortion
59857	C	Abortion
59866	C	Abortion
60212	C	Parital thyroid excision
60252	C	Removal of thyroid
60254	C	Extensive thyroid surgery
60260	C	Repeat thyroid surgery
60270	C	Removal of thyroid
60271	C	Removal of thyroid
60500	C	Explore parathyroid glands
60502	C	Re-explore parathyroids
60505	C	Explore parathyroid glands
60512	C	Autotransplant, parathyroid
60520	C	Removal of thymus gland
60521	C	Removal thymus gland
60522	C	Removal of thymus gland
60540	C	Explore adrenal gland
60545	C	Explore adrenal gland
60600	C	Remove carotid body lesion
60605	C	Remove carotid body lesion
61105	C	Drill skull for examination
61106	C	Drill skull for exam/surgery
61107	C	Drill skull for implantation

ADDENDUM G.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description
61108	C	Drill skull for drainage
61120	C	Pierce skull for examination
61130	C	Pierce skull, exam/surgery
61140	C	Pierce skull for biopsy
61150	C	Pierce skull for drainage
61151	C	Pierce skull for drainage
61154	C	Pierce skull, remove clot
61156	C	Pierce skull for drainage
61210	C	Pierce skull; implant device
61250	C	Pierce skull & explore
61253	C	Pierce skull & explore
61304	C	Open skull for exploration
61305	C	Open skull for exploration
61312	C	Open skull for drainage
61313	C	Open skull for drainage
61314	C	Open skull for drainage
61315	C	Open skull for drainage
61320	C	Open skull for drainage
61321	C	Open skull for drainage
61330	C	Decompress eye socket
61332	C	Explore/biopsy eye socket
61333	C	Explore orbit; remove lesion
61334	C	Explore orbit; remove object
61340	C	Relieve cranial pressure
61343	C	Incise skull, pressure relief
61345	C	Relieve cranial pressure
61440	C	Incise skull for surgery
61450	C	Incise skull for surgery
61458	C	Incise skull for brain wound
61460	C	Incise skull for surgery
61470	C	Incise skull for surgery
61480	C	Incise skull for surgery
61490	C	Incise skull for surgery
61500	C	Removal of skull lesion
61501	C	Remove infected skull bone
61510	C	Removal of brain lesion
61512	C	Remove brain lining lesion
61514	C	Removal of brain abscess
61516	C	Removal of brain lesion
61518	C	Removal of brain lesion
61519	C	Remove brain lining lesion
61520	C	Removal of brain lesion
61521	C	Removal of brain lesion
61522	C	Removal of brain abscess
61524	C	Removal of brain lesion
61526	C	Removal of brain lesion
61530	C	Removal of brain lesion
61531	C	Implant brain electrodes
61533	C	Implant brain electrodes
61534	C	Removal of brain lesion
61535	C	Remove brain electrodes
61536	C	Removal of brain lesion
61538	C	Removal of brain tissue
61539	C	Removal of brain tissue
61541	C	Incision of brain tissue
61542	C	Removal of brain tissue
61543	C	Removal of brain tissue
61544	C	Remove & treat brain lesion
61545	C	Excision of brain tumor
61546	C	Removal of pituitary gland
61548	C	Removal of pituitary gland
61550	C	Release of skull seams
61552	C	Release of skull seams
61556	C	Incise skull/sutures
61557	C	Incise skull/sutures
61558	C	Excision of skull/sutures
61559	C	Excision of skull/sutures
61563	C	Excision of skull tumor
61564	C	Excision of skull tumor
61570	C	Remove brain foreign body
61571	C	Incise skull for brain wound
61575	C	Skull base/brainstem surgery
61576	C	Skull base/brainstem surgery

ADDENDUM G.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description
61580	C	Craniofacial approach, skull
61581	C	Craniofacial approach, skull
61582	C	Craniofacial approach, skull
61583	C	Craniofacial approach, skull
61584	C	Orbitocranial approach/skull
61585	C	Orbitocranial approach/skull
61586	C	Resect nasopharynx, skull
61590	C	Infratemporal approach/skull
61591	C	Infratemporal approach/skull
61592	C	Orbitocranial approach/skull
61595	C	Transtemporal approach/skull
61596	C	Transcochlear approach/skull
61597	C	Transcondylar approach/skull
61598	C	Transpetrosal approach/skull
61600	C	Resect/excise cranial lesion
61601	C	Resect/excise cranial lesion
61605	C	Resect/excise cranial lesion
61606	C	Resect/excise cranial lesion
61607	C	Resect/excise cranial lesion
61608	C	Resect/excise cranial lesion
61609	C	Transect, artery, sinus
61610	C	Transect, artery, sinus
61611	C	Transect, artery, sinus
61612	C	Transect, artery, sinus
61613	C	Remove aneurysm, sinus
61615	C	Resect/excise lesion, skull
61616	C	Resect/excise lesion, skull
61618	C	Repair dura
61619	C	Repair dura
61624	C	Occlusion/embolization cath
61626	C	Occlusion/embolization cath
61680	C	Intracranial vessel surgery
61682	C	Intracranial vessel surgery
61684	C	Intracranial vessel surgery
61686	C	Intracranial vessel surgery
61690	C	Intracranial vessel surgery
61692	C	Intracranial vessel surgery
61700	C	Inner skull vessel surgery
61702	C	Inner skull vessel surgery
61703	C	Clamp neck artery
61705	C	Revise circulation to head
61708	C	Revise circulation to head
61710	C	Revise circulation to head
61711	C	Fusion of skull arteries
61712	C	Skull or spine microsurgery
61720	C	Incise skull/brain surgery
61735	C	Incise skull/brain surgery
61750	C	Incise skull; brain biopsy
61751	C	Brain biopsy with cat scan
61760	C	Implant brain electrodes
61770	C	Incise skull for treatment
61791	C	Treat trigeminal tract
61795	C	Brain surgery using computer
61850	C	Implant neuroelectrodes
61855	C	Implant neuroelectrodes
61860	C	Implant neuroelectrodes
61865	C	Implant neuroelectrodes
61870	C	Implant neuroelectrodes
61875	C	Implant neuroelectrodes
61880	C	Revise/remove neuroelectrode
61888	C	Revise/remove neuroreceiver
62000	C	Repair of skull fracture
62005	C	Repair of skull fracture
62010	C	Treatment of head injury
62100	C	Repair brain fluid leakage
62115	C	Reduction of skull defect
62116	C	Reduction of skull defect
62117	C	Reduction of skull defect
62120	C	Repair skull cavity lesion
62121	C	Incise skull repair
62140	C	Repair of skull defect
62141	C	Repair of skull defect
62142	C	Remove skull plate/flap

ADDENDUM G.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description
62143	C	Replace skull plate/flap
62145	C	Repair of skull & brain
62146	C	Repair of skull with graft
62147	C	Repair of skull with graft
62180	C	Establish brain cavity shunt
62190	C	Establish brain cavity shunt
62192	C	Establish brain cavity shunt
62200	C	Establish brain cavity shunt
62201	C	Establish brain cavity shunt
62220	C	Establish brain cavity shunt
62223	C	Establish brain cavity shunt
62256	C	Remove brain cavity shunt
62258	C	Replace brain cavity shunt
62351	C	Implant spinal catheter
63001	C	Removal of spinal lamina
63003	C	Removal of spinal lamina
63005	C	Removal of spinal lamina
63011	C	Removal of spinal lamina
63012	C	Removal of spinal lamina
63015	C	Removal of spinal lamina
63016	C	Removal of spinal lamina
63017	C	Removal of spinal lamina
63020	C	Neck spine disk surgery
63030	C	Low back disk surgery
63035	C	Added spinal disk surgery
63040	C	Neck spine disk surgery
63042	C	Low back disk surgery
63045	C	Removal of spinal lamina
63046	C	Removal of spinal lamina
63047	C	Removal of spinal lamina
63048	C	Removal of spinal lamina
63055	C	Decompress spinal cord
63056	C	Decompress spinal cord
63057	C	Decompress spinal cord
63064	C	Decompress spinal cord
63066	C	Decompress spinal cord
63075	C	Neck spine disk surgery
63076	C	Neck spine disk surgery
63077	C	Spine disk surgery, thorax
63078	C	Spine disk surgery, thorax
63081	C	Removal of vertebral body
63082	C	Removal of vertebral body
63085	C	Removal of vertebral body
63086	C	Removal of vertebral body
63087	C	Removal of vertebral body
63088	C	Removal of vertebral body
63090	C	Removal of vertebral body
63091	C	Removal of vertebral body
63170	C	Incise spinal cord tract(s)
63172	C	Drainage of spinal cyst
63173	C	Drainage of spinal cyst
63180	C	Revise spinal cord ligaments
63182	C	Revise spinal cord ligaments
63185	C	Incise spinal column/nerves
63190	C	Incise spinal column/nerves
63191	C	Incise spinal column/nerves
63194	C	Incise spinal column & cord
63195	C	Incise spinal column & cord
63196	C	Incise spinal column & cord
63197	C	Incise spinal column & cord
63198	C	Incise spinal column & cord
63199	C	Incise spinal column & cord
63200	C	Release of spinal cord
63250	C	Revise spinal cord vessels
63251	C	Revise spinal cord vessels
63252	C	Revise spinal cord vessels
63265	C	Excise intraspinal lesion
63266	C	Excise intraspinal lesion
63267	C	Excise intraspinal lesion
63268	C	Excise intraspinal lesion
63270	C	Excise intraspinal lesion
63271	C	Excise intraspinal lesion
63272	C	Excise intraspinal lesion

ADDENDUM G.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description
63273	C	Excise intraspinal lesion
63275	C	Biopsy/excise spinal tumor
63276	C	Biopsy/excise spinal tumor
63277	C	Biopsy/excise spinal tumor
63278	C	Biopsy/excise spinal tumor
63280	C	Biopsy/excise spinal tumor
63281	C	Biopsy/excise spinal tumor
63282	C	Biopsy/excise spinal tumor
63283	C	Biopsy/excise spinal tumor
63285	C	Biopsy/excise spinal tumor
63286	C	Biopsy/excise spinal tumor
63287	C	Biopsy/excise spinal tumor
63290	C	Biopsy/excise spinal tumor
63300	C	Removal of vertebral body
63301	C	Removal of vertebral body
63302	C	Removal of vertebral body
63303	C	Removal of vertebral body
63304	C	Removal of vertebral body
63305	C	Removal of vertebral body
63306	C	Removal of vertebral body
63307	C	Removal of vertebral body
63308	C	Removal of vertebral body
63655	C	Implant neuroelectrodes
63700	C	Repair of spinal herniation
63702	C	Repair of spinal herniation
63704	C	Repair of spinal herniation
63706	C	Repair of spinal herniation
63707	C	Repair spinal fluid leakage
63709	C	Repair spinal fluid leakage
63710	C	Graft repair of spine defect
63740	C	Install spinal shunt
63741	C	Install spinal shunt
64752	C	Incision of vagus nerve
64755	C	Incision of stomach nerves
64760	C	Incision of vagus nerve
64763	C	Incise hip/thigh nerve
64766	C	Incise hip/thigh nerve
64802	C	Remove sympathetic nerves
64804	C	Remove sympathetic nerves
64809	C	Remove sympathetic nerves
64818	C	Remove sympathetic nerves
64820	C	Remove sympathetic nerves
64866	C	Fusion of facial/other nerve
64868	C	Fusion of facial/other nerve
65110	C	Removal of eye
65112	C	Remove eye, revise socket
65114	C	Remove eye, revise socket
65273	C	Repair of eye wound
67414	C	Explore/decompress eye socke
67445	C	Explore/decompress eye socke
67570	C	Decompress optic nerve
69155	C	Extensive ear/neck surgery
69535	C	Remove part of temporal bone
69554	C	Remove ear lesion
69950	C	Incise inner ear nerve
69955	C	Release facial nerve
69960	C	Release inner ear canal
69970	C	Remove inner ear lesion
69979	C	Temporal bone surgery
74300	C	X-ray bile ducts, pancreas
74301	C	Additional x-rays at surgery
75894	C	Xrays, transcatheter therapy
75896	C	Xrays, transcatheter therapy
75900	C	Arterial catheter exchange
75940	C	X-ray placement, vein filter
75945	C	Intravascular us
75946	C	Intravascular us
75960	C	Transcatheter intro, stent
75961	C	Retrieval, broken catheter
75962	C	Repair arterial blockage
75964	C	Repair artery blockage, each

ADDENDUM G.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description
75966	C	Repair arterial blockage
75968	C	Repair artery blockage, each
75970	C	Vascular biopsy
75978	C	Repair venous blockage
75992	C	Atherectomy, x-ray exam
75993	C	Atherectomy, x-ray exam
75994	C	Atherectomy, x-ray exam
75995	C	Atherectomy, x-ray exam
75996	C	Atherectomy, x-ray exam
92970	C	Cardioassist, internal
92971	C	Cardioassist, external
92975	C	Dissolve clot, heart vessel
92977	C	Dissolve clot, heart vessel
92978	C	Intravas us, heart (add-on)
92979	C	Intravas us, heart (add-on)
92980	C	Insert intracoronary stent
92981	C	Insert intracoronary stent
92982	C	Coronary artery dilation

ADDENDUM G.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description
92984	C	Coronary artery dilation
92986	C	Revision of aortic valve
92987	C	Revision of mitral valve
92990	C	Revision of pulmonary valve
92992	C	Revision of heart chamber
92993	C	Revision of heart chamber
92995	C	Coronary atherectomy
92996	C	Coronary atherectomy
92997	C	Pul art balloon repair, perc
92998	C	Pul art balloon repair, perc
94652	C	Pressure breathing (IPPB)
94656	C	Initial ventilator mgmt
95920	C	Intraoperative nerve testing
95961	C	Electrode stimulation, brain
95962	C	Electrode stimulation, brain
99190	C	Special pump services
99191	C	Special pump services
99192	C	Special pump services

ADDENDUM G.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description
99234	C	Observ/hosp same date
99235	C	Observ/hosp same date
99236	C	Observ/hosp same date
99251	C	Initial inpatient consult
99252	C	Initial inpatient consult
99253	C	Initial inpatient consult
99254	C	Initial inpatient consult
99255	C	Initial inpatient consult
99261	C	Follow-up inpatient consult
99262	C	Follow-up inpatient consult
99263	C	Follow-up inpatient consult
99295	C	Neonatal critical care
99296	C	Neonatal critical care
99297	C	Neonatal critical care
99356	C	Prolonged service, inpatient
99357	C	Prolonged service, inpatient
99433	C	Normal newborn care,hospital

ADDENDUM H.—STATUS INDICATORS; HOW VARIOUS SERVICES ARE TREATED UNDER OUTPATIENT PPS

Indicator	Service	Status
A	Pulmonary Rehabilitation Clinical Trial	Not paid under PPS
C	Inpatient Procedures	Admit Patient; Bill as Inpatient
A	Durable Medical Equipment, Prosthetics and Orthotics	DMEPOS Fee Schedule
E	Non-covered Items and Services	Non-paid
A	Physical, Occupational and Speech Therapy	Rehabilitation Fee Schedule
A	Ambulance	Ambulance Fee Schedule
A	EPO for ESRD patients	National Rate
A	Clinical Diagnostic Laboratory Services	Laboratory Fee Schedule
A	Physician Services for ESRD patients	Not paid under PPS
A	Screening Mammography	National Rate
N	Incidental Services, packaged into APC Rate	Packaged
P	Partial Hospitalization	Paid per diem APC
S	Significant Procedure, not discounted when multiple	Paid
T	Procedure, multiple discount applies	Paid
V	Visit to Clinic or Emergency Department	Paid
X	Ancillary Service	Paid

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL

Hospital	SMI
010001	2.17
010004	1.18
010005	1.37
010006	1.95
010007	1.07
010008	1.16
010009	1.18
010010	1.40
010011	1.64
010012	1.32
010015	1.40
010016	2.19
010018	4.13
010019	1.91
010021	1.24
010022	1.30
010023	2.49
010024	1.95
010025	1.38
010027	0.76
010029	1.97
010031	1.32
010032	0.83
010033	1.17
010034	1.48
010035	2.18
010036	1.16

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
010038	2.60
010039	1.40
010040	2.15
010043	1.31
010044	1.38
010045	1.25
010046	1.43
010047	0.97
010049	1.93
010050	1.14
010051	1.06
010052	0.89
010053	1.37
010054	1.30
010055	2.14
010056	1.66
010058	0.57
010059	1.22
010061	1.66
010062	1.14
010064	1.95
010065	1.52
010066	0.77
010068	0.97
010069	1.56
010072	1.49
010073	1.32

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
010078	1.65
010079	1.59
010080	0.75
010081	1.86
010083	1.37
010084	3.64
010087	1.89
010089	1.67
010090	1.80
010091	1.02
010092	1.67
010094	1.23
010095	0.91
010097	1.23
010098	1.05
010099	1.32
010100	1.67
010101	1.42
010102	0.85
010103	1.63
010104	1.75
010108	1.18
010109	1.33
010110	0.82
010112	1.15
010113	1.97
010114	1.52

Note: The median service mix for all hospitals is 1.45

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
010115	0.94
010117	0.80
010118	1.77
010119	1.56
010120	1.24
010123	1.62
010124	2.29
010125	0.91
010126	1.80
010127	1.88
010128	0.91
010129	1.10
010130	1.13
010131	1.88
010134	1.02
010137	0.97
010138	0.86
010139	2.05
010143	1.42
010144	2.30
010145	1.16
010146	1.76
010148	1.30
010149	1.70
010150	1.60
010152	1.49
010155	1.00
012005	1.01
013025	1.08
013027	0.80
013028	0.66
013029	1.07
013030	0.40
013300	0.87
014000	0.86
014002	0.85
014003	0.83
020001	2.09
020002	1.79
020004	1.27
020005	0.69
020006	1.37
020007	0.58
020008	1.36
020009	0.71
020010	0.38
020011	0.68
020012	2.31
020013	1.41
020014	1.05
020017	2.01
020024	1.21
020025	0.68
024001	0.97
030001	1.79
030002	1.72
030003	1.36
030004	0.58
030006	1.90
030007	1.72
030008	2.23
030009	0.94
030010	1.69
030011	2.18
030012	1.24
030013	1.74
030014	1.81
030016	1.26
030017	2.04
030018	2.22
030019	1.67
030022	1.17
030023	1.69
030024	2.35
030025	1.07
030027	0.94

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
030030	2.01
030033	1.38
030034	0.77
030035	2.11
030036	1.65
030037	2.92
030038	2.39
030040	1.22
030041	0.85
030043	1.66
030044	1.34
030047	1.01
030049	0.50
030054	0.57
030055	1.65
030059	1.77
030060	1.43
030061	1.44
030062	1.32
030064	1.67
030065	2.01
030067	1.01
030068	1.71
030069	2.11
030080	1.67
030083	1.52
030085	1.78
030086	1.52
030087	3.31
030088	1.58
030089	1.83
030092	1.84
030093	1.16
030094	1.42
030095	1.99
033025	1.10
033026	1.27
033028	1.06
034004	0.89
034008	0.92
034009	0.87
034010	0.87
034013	0.92
034015	0.87
034019	0.87
040001	1.28
040002	1.32
040003	1.12
040004	2.28
040005	1.32
040007	3.03
040008	0.82
040010	2.01
040011	0.98
040014	1.96
040015	1.00
040016	1.43
040017	1.71
040018	1.55
040019	1.59
040020	1.88
040021	2.05
040022	1.39
040024	1.10
040025	1.03
040026	1.75
040027	2.26
040028	1.09
040029	2.25
040030	0.89
040032	0.63
040035	0.75
040036	2.40
040037	1.04
040039	1.54
040040	0.87

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
040041	2.17
040042	1.31
040044	0.90
040045	1.17
040047	1.14
040048	1.69
040050	1.28
040051	1.14
040053	1.01
040054	1.68
040055	1.97
040058	1.26
040060	0.80
040062	1.75
040064	0.75
040066	2.43
040067	0.73
040069	1.84
040070	1.19
040071	1.30
040072	1.26
040074	1.65
040075	1.08
040076	1.13
040077	1.05
040078	2.58
040080	1.19
040081	0.62
040082	1.05
040084	1.68
040085	1.19
040088	1.98
040090	0.75
040091	1.19
040093	0.79
040100	1.19
040105	0.79
040106	1.28
040107	1.23
040109	1.10
040114	4.13
040116	2.11
040118	2.05
040119	1.78
040124	1.44
040126	1.58
040132	0.55
043026	1.00
043027	0.59
043028	0.84
043029	1.09
043031	0.57
043032	2.32
043300	1.25
044004	0.86
044005	0.88
044006	0.99
044010	1.02
044011	1.22
044012	0.87
050002	1.32
050006	1.90
050007	1.51
050008	1.66
050009	2.00
050013	1.37
050014	1.64
050015	1.65
050016	1.33
050017	3.14
050018	1.71
050021	1.89
050022	1.82
050024	1.27
050025	1.51
050026	1.47

Note: The median service mix for all hospitals is 1.45

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
050028	1.74
050029	1.52
050030	1.19
050032	1.83
050033	1.48
050036	1.87
050038	0.97
050039	1.59
050042	1.90
050043	1.96
050045	2.02
050046	1.29
050047	2.10
050051	1.00
050054	1.05
050055	1.00
050056	2.22
050057	1.79
050058	1.75
050060	1.35
050061	3.66
050063	1.75
050065	1.82
050066	1.58
050067	1.28
050068	1.58
050069	1.74
050077	1.69
050078	1.44
050079	1.44
050080	1.28
050081	0.76
050082	1.83
050084	1.62
050088	0.88
050089	1.28
050090	1.74
050091	2.15
050092	1.12
050093	2.09
050095	2.30
050096	1.07
050097	2.60
050099	1.51
050100	1.55
050101	1.84
050102	1.20
050103	1.80
050104	1.28
050107	1.81
050108	1.89
050109	1.63
050110	2.15
050111	4.65
050112	1.70
050113	0.86
050114	1.16
050115	1.17
050116	1.84
050117	1.85
050118	1.57
050121	2.17
050122	1.88
050124	1.35
050125	2.05
050126	1.96
050127	1.21
050128	1.51
050129	1.99
050131	1.59
050132	1.46
050133	1.50
050135	1.02
050136	1.65
050137	1.40
050138	6.45
050139	5.33
050140	2.13
050144	1.48
050145	1.65
050147	0.87
050148	1.44
050149	1.31
050150	1.63
050152	1.47
050153	1.61
050155	1.55
050158	2.29
050159	0.92
050167	0.91
050168	2.16
050169	1.74
050170	1.58
050172	1.15
050173	1.94
050174	2.40
050175	2.19
050177	1.24
050179	1.57
050180	1.38
050183	0.85
050186	1.01
050188	2.43
050189	1.39
050191	1.67
050192	1.03
050193	1.02
050194	1.62
050195	1.64
050196	1.47
050197	1.72
050204	2.12
050205	1.23
050207	2.14
050208	1.82
050211	1.70
050213	0.87
050214	1.49
050215	1.99
050217	1.50
050219	1.30
050222	1.71
050224	1.77
050225	1.36
050226	1.82
050228	0.83
050230	1.83
050231	3.90
050232	1.83
050233	1.56
050234	1.11
050235	1.81
050236	1.43
050238	1.29
050239	1.61
050240	1.79
050241	1.47
050242	1.55
050243	1.35
050245	0.80
050248	0.94
050251	1.29
050253	0.87
050254	2.05
050256	1.00
050257	0.99
050260	0.73
050261	1.33
050262	1.51
050264	1.57
050267	1.76
050270	1.79
050272	1.00
050274	0.97
050276	0.82
050277	0.95
050278	1.65
050279	1.47
050280	1.77
050281	2.70
050282	1.50
050283	0.80
050286	0.66
050289	1.71
050290	1.53
050291	1.11
050292	0.96
050293	1.01
050295	1.82
050296	1.42
050298	1.38
050299	2.41
050300	1.97
050301	1.85
050302	2.08
050305	1.24
050307	1.90
050308	1.59
050309	1.86
050310	2.15
050312	1.61
050313	1.91
050315	0.79
050317	1.14
050320	0.82
050324	2.00
050325	1.13
050327	1.41
050328	2.07
050329	0.95
050331	1.37
050333	0.66
050334	2.40
050335	0.87
050336	1.52
050337	1.14
050342	1.35
050343	2.06
050348	1.07
050349	0.79
050350	1.29
050351	2.19
050352	1.43
050353	1.85
050355	0.70
050357	1.43
050359	1.99
050360	1.91
050366	1.30
050367	1.24
050369	1.65
050377	0.63
050378	1.36
050379	1.01
050380	2.26
050382	1.93
050385	1.50
050388	0.70
050390	1.65
050391	1.74
050392	1.11
050393	2.05
050394	2.34
050396	2.78
050397	0.89
050401	1.47
050404	0.97
050406	0.85

Note: The median service mix for all hospitals is 1.45

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
050407	1.88
050410	0.67
050411	3.99
050414	1.85
050417	1.81
050418	0.88
050419	1.63
050420	1.18
050421	1.64
050423	1.31
050424	2.03
050426	2.03
050427	0.54
050430	0.92
050431	2.44
050432	1.91
050433	0.99
050434	0.87
050435	1.52
050436	1.04
050438	1.44
050440	0.94
050441	1.43
050443	0.92
050444	1.74
050446	0.93
050447	1.14
050448	2.02
050449	2.24
050454	1.18
050455	2.27
050456	3.32
050457	1.34
050459	1.62
050464	2.06
050468	1.25
050469	1.07
050470	1.37
050471	2.08
050476	1.66
050477	2.95
050478	1.03
050481	2.09
050482	0.68
050483	1.07
050485	2.20
050486	1.97
050488	1.39
050491	1.64
050492	1.50
050494	2.02
050496	1.71
050497	0.69
050498	1.60
050502	2.55
050503	2.26
050506	1.59
050515	9.08
050516	2.17
050517	1.62
050522	1.91
050523	1.38
050526	0.94
050528	1.34
050531	3.15
050534	1.59
050535	1.82
050537	1.75
050539	1.29
050542	1.40
050543	1.13
050545	0.69
050546	0.66
050547	0.76
050548	0.74
050549	1.90

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
050550	2.12
050551	1.73
050552	0.84
050557	1.41
050559	1.43
050560	2.06
050561	2.70
050564	1.37
050565	1.22
050566	1.01
050567	1.57
050568	1.73
050569	1.58
050570	1.70
050571	1.96
050573	1.69
050577	2.79
050578	0.73
050579	1.68
050580	1.49
050581	1.60
050583	2.12
050584	1.30
050585	1.59
050586	1.91
050588	1.69
050589	1.89
050590	2.07
050591	2.43
050592	1.91
050593	1.34
050594	1.76
050597	1.82
050598	2.19
050599	1.07
050601	2.01
050603	1.16
050607	0.80
050608	1.17
050609	1.29
050613	0.56
050615	2.57
050616	1.75
050618	0.63
050624	1.63
050625	1.96
050630	1.57
050633	1.63
050636	1.58
050638	0.95
050641	1.75
050644	1.85
050661	0.87
050662	0.77
050663	1.40
050666	0.75
050667	0.76
050668	0.73
050675	1.66
050676	0.62
050677	1.36
050678	1.54
050680	1.00
050682	0.77
050684	1.39
050685	1.72
050686	1.98
050688	1.10
050689	1.57
050693	1.61
050694	1.42
050695	1.12
050696	2.25
050697	2.81
050699	0.94
050700	1.65

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
050701	1.31
050702	0.67
050704	0.90
050707	14.19
050708	10.17
050709	2.00
052031	0.57
053026	1.10
053027	0.70
053028	0.78
053029	0.96
053030	0.71
053031	0.90
053032	0.60
053033	0.93
053034	1.10
053035	1.06
053036	0.83
053037	1.02
053300	0.98
053301	1.27
053302	1.00
053304	0.81
053305	0.65
054001	0.87
054003	0.87
054009	0.88
054012	0.73
054028	0.91
054032	0.64
054050	1.09
054052	0.81
054053	0.99
054055	0.83
054060	0.87
054064	0.83
054065	0.70
054069	0.67
054074	0.87
054075	0.87
054077	0.87
054078	0.89
054085	0.87
054087	0.78
054091	0.83
054093	0.88
054094	0.88
054095	0.87
054096	0.88
054097	0.77
054098	0.87
054099	0.87
054104	0.88
054105	0.87
054106	0.87
054108	0.88
054110	0.87
054111	0.76
054113	0.87
054115	0.87
054116	0.88
054117	0.87
054119	0.87
054122	0.84
054123	0.90
054125	0.99
054126	0.84
054130	0.71
054131	0.96
054133	0.85
054139	0.74
060001	1.99
060003	1.61
060004	1.07
060006	1.40
060007	1.23

Note: The median service mix for all hospitals is 1.45

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
060008	1.36
060009	1.52
060010	1.62
060011	0.87
060012	1.19
060013	1.25
060014	1.69
060015	1.18
060016	1.38
060018	1.61
060020	1.40
060022	1.18
060023	1.77
060024	1.08
060027	1.45
060028	1.69
060029	0.76
060030	1.94
060031	1.60
060032	1.84
060033	1.07
060034	1.44
060036	1.30
060037	0.93
060038	0.89
060041	0.71
060042	1.10
060043	0.85
060044	1.42
060046	1.98
060047	0.61
060049	1.82
060050	1.25
060052	1.09
060053	1.12
060054	1.94
060056	0.86
060057	1.36
060058	0.90
060060	1.12
060062	0.97
060063	0.59
060064	2.03
060065	1.79
060068	0.85
060070	1.04
060071	1.40
060073	1.14
060075	2.15
060076	1.29
060085	0.67
060087	1.53
060088	1.00
060090	0.98
060096	1.69
060100	1.39
060103	2.74
060104	1.65
062009	0.56
062011	1.54
063026	0.66
063027	1.04
063029	1.68
063030	1.60
063301	0.93
063302	0.84
064007	0.87
064009	0.84
064010	1.03
064012	0.87
064016	0.90
070001	1.94
070002	1.78
070003	1.57
070004	1.60
070005	1.17

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
070006	1.53
070007	1.85
070008	1.32
070009	1.98
070010	1.61
070011	1.43
070012	1.47
070015	1.40
070016	1.40
070017	1.81
070018	1.58
070019	2.00
070020	1.45
070021	1.68
070022	1.67
070024	1.59
070025	1.83
070026	1.49
070027	1.35
070028	1.48
070029	1.55
070030	1.74
070031	1.25
070033	1.27
070034	1.72
070035	1.57
070036	1.39
070039	0.71
072003	3.24
072004	0.59
074000	0.88
074007	0.87
074008	1.05
074012	0.85
080001	2.01
080002	1.54
080003	1.89
080004	1.72
080005	2.03
080006	2.09
080007	1.48
083300	3.49
084002	0.85
090001	2.44
090002	1.64
090003	1.28
090004	1.64
090005	3.11
090006	1.65
090007	0.98
090008	1.67
090010	3.66
090011	2.05
090015	0.45
093025	0.72
093300	1.30
094004	0.83
100001	1.06
100002	1.64
100004	1.02
100006	1.46
100007	2.13
100008	2.17
100009	1.70
100010	1.72
100012	1.78
100014	1.50
100015	1.87
100017	1.69
100018	1.33
100019	2.56
100020	2.02
100022	0.97
100023	1.98
100024	2.03
100025	1.48

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
100026	1.75
100027	1.01
100028	2.09
100029	1.41
100030	1.98
100032	1.36
100034	1.52
100035	1.72
100038	1.35
100039	2.01
100040	2.03
100043	1.52
100044	1.71
100045	1.54
100046	1.49
100047	1.26
100048	1.07
100049	1.78
100050	1.69
100051	1.51
100052	2.11
100053	1.82
100054	1.38
100055	1.74
100056	2.29
100057	2.09
100060	1.86
100061	1.71
100062	1.99
100063	1.72
100067	1.72
100068	1.44
100069	1.78
100070	1.59
100071	1.31
100072	1.32
100073	1.26
100075	1.48
100076	1.70
100077	2.49
100078	0.75
100080	1.72
100081	1.10
100082	1.63
100084	1.49
100085	1.16
100086	1.65
100087	2.28
100088	2.12
100090	1.93
100092	1.75
100093	1.85
100098	0.79
100099	1.92
100102	1.22
100103	0.73
100105	1.68
100106	1.55
100107	1.38
100108	1.16
100109	1.78
100110	1.45
100112	0.66
100113	1.90
100114	1.70
100117	2.13
100118	1.37
100121	1.75
100122	1.98
100124	1.45
100125	1.53
100126	1.53
100127	2.01
100128	1.83
100129	2.14
100130	1.43

Note: The median service mix for all hospitals is 1.45

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
100131	1.86
100132	1.62
100134	0.90
100135	2.75
100137	1.45
100138	0.74
100139	0.94
100140	1.56
100142	1.47
100144	2.03
100145	1.58
100146	0.98
100147	0.82
100150	1.46
100151	2.14
100154	2.20
100156	1.32
100157	2.28
100159	0.92
100160	1.32
100161	1.33
100162	1.50
100165	1.51
100166	1.31
100167	3.04
100168	1.86
100169	1.82
100170	1.83
100172	0.97
100173	2.15
100174	1.46
100175	1.00
100176	1.67
100177	2.17
100179	2.60
100180	1.43
100181	2.56
100183	1.79
100187	1.84
100189	1.64
100191	1.77
100199	1.74
100200	2.55
100203	1.35
100204	1.76
100206	2.07
100208	1.27
100209	1.49
100210	1.37
100211	1.37
100212	1.65
100213	1.07
100217	2.28
100220	1.93
100221	1.55
100222	0.88
100223	1.50
100224	1.67
100225	1.63
100226	1.36
100228	2.07
100229	1.31
100230	1.16
100231	1.51
100232	1.33
100234	1.48
100235	1.49
100236	1.45
100237	1.83
100238	1.91
100239	1.86
100240	3.25
100241	1.33
100242	1.47
100243	1.28
100244	1.72

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
100246	2.06
100248	1.63
100249	1.80
100252	1.73
100253	1.80
100254	1.34
100255	2.19
100256	1.73
100258	1.84
100259	1.87
100260	2.23
100262	2.19
100263	1.74
100264	1.44
100265	1.46
100266	1.68
100267	1.86
100268	1.68
100269	2.11
100270	0.71
100271	1.26
100275	1.48
100276	2.14
100277	0.65
100279	1.38
100280	1.22
100281	1.39
100282	1.05
102006	0.68
102007	0.68
102008	0.70
102009	0.69
102013	2.55
103026	1.00
103027	1.16
103028	1.00
103030	0.65
103031	0.83
103032	1.25
103033	0.98
103034	0.97
103036	2.58
103037	1.10
103039	1.00
103300	7.82
103301	1.80
104001	0.46
104002	0.39
104005	0.90
104007	0.48
104008	0.92
104015	0.79
104016	0.85
104017	0.87
104018	0.84
104024	0.94
104026	0.78
104029	0.87
104034	0.87
104036	0.83
104037	0.87
104038	0.87
104040	0.84
104041	0.84
104045	0.74
104046	0.88
104047	0.84
104052	0.86
104054	0.87
104056	0.87
104057	0.87
104060	0.88
110001	1.79
110002	1.20
110003	1.68
110004	1.67

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
110005	1.63
110006	2.18
110007	1.70
110008	1.51
110009	0.79
110010	2.18
110011	1.69
110013	1.06
110014	1.34
110015	1.16
110016	2.15
110017	0.87
110018	1.44
110020	2.09
110023	1.74
110024	2.23
110025	2.03
110026	1.20
110027	0.96
110028	1.98
110029	1.30
110030	1.69
110031	2.13
110032	1.80
110033	2.46
110034	0.96
110035	1.85
110037	1.10
110038	1.50
110039	1.99
110040	1.68
110041	1.64
110042	1.39
110043	2.40
110044	1.77
110045	1.93
110046	1.89
110048	0.97
110049	0.82
110050	1.04
110051	1.23
110052	0.70
110054	1.63
110056	0.86
110059	1.69
110061	0.77
110062	0.63
110063	1.28
110064	1.33
110065	0.73
110066	1.77
110069	2.30
110070	1.18
110071	0.78
110072	0.99
110073	1.47
110074	1.92
110075	1.43
110076	1.93
110078	1.94
110079	0.80
110080	1.62
110082	2.52
110083	2.25
110086	1.24
110087	1.83
110088	0.61
110089	1.66
110091	2.11
110092	1.14
110093	0.54
110094	0.65
110095	1.69
110096	1.12
110097	0.86
110098	0.90

Note: The median service mix for all hospitals is 1.45

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
110100	0.81
110101	0.94
110103	0.80
110104	1.47
110105	2.14
110107	1.34
110108	0.53
110109	0.97
110111	1.25
110112	0.89
110113	0.94
110114	1.18
110115	1.85
110118	0.49
110120	0.76
110121	2.61
110122	1.77
110124	1.47
110125	2.34
110127	0.94
110128	1.67
110129	1.88
110130	1.03
110132	1.22
110134	0.76
110135	2.17
110136	0.73
110140	1.50
110141	0.74
110142	0.98
110143	1.96
110144	1.16
110146	1.38
110149	1.01
110150	1.84
110152	1.07
110153	1.97
110155	0.97
110156	1.40
110161	2.31
110163	2.66
110164	2.06
110165	1.75
110166	1.76
110168	2.11
110169	4.16
110171	1.46
110172	2.42
110174	1.22
110176	1.81
110177	2.02
110178	5.17
110179	1.57
110181	0.88
110183	1.25
110184	1.38
110185	1.00
110186	2.20
110187	1.44
110188	1.69
110189	1.46
110190	1.07
110191	2.22
110192	1.58
110193	1.86
110194	0.88
110195	0.93
110198	2.26
110200	2.96
110201	1.64
110203	0.92
110205	1.12
110207	0.90
110208	1.02
110209	0.87
112000	0.74

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
112003	1.11
112004	0.55
113026	0.88
113027	1.00
113300	1.92
114000	0.87
114002	0.90
114003	0.87
114008	0.87
114010	0.95
114012	0.87
114015	0.73
114016	0.87
114017	0.87
114020	0.87
114022	0.87
114023	1.07
114024	0.89
114025	0.88
114030	0.99
114031	0.87
114032	0.93
114033	0.86
114034	0.87
120001	1.96
120002	1.75
120003	1.36
120004	1.42
120005	2.13
120006	1.51
120007	2.14
120009	0.77
120010	1.83
120012	0.86
120014	1.93
120018	0.50
120019	1.67
120022	0.91
120024	0.55
120025	0.54
120026	1.90
120027	1.30
122001	0.55
123025	0.98
123300	1.31
124001	0.87
130001	1.01
130002	1.74
130003	1.89
130005	3.16
130006	1.41
130007	2.35
130008	1.14
130009	1.62
130010	0.61
130011	2.22
130012	1.01
130013	1.74
130014	3.11
130015	0.83
130016	1.29
130017	1.35
130018	1.34
130019	1.49
130021	0.71
130022	2.96
130024	1.71
130025	1.44
130026	4.85
130027	1.11
130028	2.66
130029	1.22
130030	0.59
130031	1.59
130034	1.10
130035	1.22

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
130036	2.54
130037	1.41
130043	1.22
130044	0.97
130045	1.41
130048	0.73
130049	2.21
130054	0.41
130056	0.52
130060	2.39
130061	1.14
133025	0.98
134002	0.86
134003	0.87
134009	0.89
140001	1.59
140002	1.55
140003	0.97
140004	1.72
140005	0.91
140007	1.70
140008	1.74
140010	1.53
140011	1.20
140012	1.37
140013	1.73
140014	1.60
140015	1.51
140016	1.22
140018	1.27
140019	1.03
140024	1.12
140025	1.03
140026	1.38
140027	1.23
140029	1.37
140030	1.91
140031	1.01
140032	1.49
140033	1.74
140034	1.41
140035	1.12
140036	1.63
140037	1.11
140038	0.93
140040	1.53
140041	1.22
140042	1.03
140043	1.96
140045	0.98
140046	1.49
140047	0.81
140048	1.32
140049	1.34
140051	1.65
140052	1.64
140053	2.10
140054	1.49
140055	0.97
140058	1.43
140059	1.52
140061	1.13
140062	1.49
140063	1.34
140064	1.88
140065	1.59
140066	1.06
140067	1.69
140068	1.16
140069	1.02
140070	1.20
140074	0.80
140075	1.74
140077	1.09
140079	1.60
140080	1.47

Note: The median service mix for all hospitals is 1.45

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
140081	1.09
140082	1.27
140083	0.97
140084	2.00
140086	1.36
140087	1.46
140088	1.07
140089	1.85
140090	1.74
140091	3.74
140093	1.60
140094	1.49
140095	1.23
140097	0.94
140100	1.86
140101	1.27
140102	1.24
140103	1.02
140105	1.69
140107	0.93
140108	1.87
140109	1.07
140110	1.37
140112	1.18
140113	1.41
140114	1.63
140115	1.42
140116	1.76
140117	1.85
140118	1.95
140119	1.80
140120	1.33
140121	1.50
140122	1.64
140125	1.34
140127	2.76
140128	1.05
140129	1.30
140130	1.67
140132	1.97
140133	1.22
140135	1.66
140137	0.82
140138	1.23
140139	1.07
140140	1.33
140141	1.17
140143	1.51
140144	1.01
140145	1.27
140146	1.33
140147	1.34
140148	1.95
140150	1.06
140151	0.92
140152	1.13
140155	1.65
140158	1.12
140160	2.20
140161	1.64
140162	1.50
140164	1.96
140165	1.45
140166	1.23
140167	1.62
140168	1.32
140170	1.01
140171	0.94
140172	1.02
140173	0.82
140174	1.54
140176	1.84
140177	1.32
140179	1.69
140180	1.34
140181	1.31

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
140182	1.07
140184	1.18
140185	1.69
140186	1.38
140187	1.32
140188	0.88
140189	1.08
140190	1.09
140191	1.21
140193	1.54
140197	1.13
140199	1.24
140200	1.17
140202	1.75
140203	1.71
140205	2.25
140206	1.54
140207	1.64
140208	1.45
140209	1.75
140210	1.30
140211	1.62
140212	0.83
140213	1.41
140215	0.83
140217	1.36
140218	1.20
140220	1.26
140223	2.05
140224	1.55
140228	1.54
140230	0.69
140231	1.57
140233	1.68
140234	1.61
140236	0.85
140239	1.86
140240	1.33
140242	1.87
140245	1.16
140246	1.08
140250	1.10
140251	2.01
140252	1.48
140253	1.85
140258	1.56
140271	0.88
140275	1.61
140276	1.63
140280	1.52
140281	1.81
140285	1.32
140286	1.49
140288	1.39
140289	1.52
140290	2.00
140291	1.60
140292	1.54
140294	1.55
140297	1.05
140300	0.85
142006	0.45
142009	3.19
143025	0.86
143026	0.82
143027	0.97
143300	1.06
144005	0.95
144009	0.83
144019	0.63
144025	0.87
144026	0.87
144029	0.83
144030	0.88
144031	0.92
144033	0.67

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
144034	0.87
144035	0.70
144036	0.87
150001	1.61
150002	1.43
150003	1.66
150004	1.39
150005	1.71
150006	1.92
150007	1.45
150008	1.65
150009	1.94
150010	1.77
150011	1.22
150012	2.09
150013	1.33
150014	1.49
150015	1.86
150018	1.79
150019	1.31
150020	1.63
150022	1.83
150023	1.53
150024	0.87
150026	1.68
150027	1.05
150029	2.35
150030	1.66
150031	1.09
150033	1.60
150034	1.72
150036	1.17
150037	1.71
150038	1.11
150039	1.50
150042	1.94
150043	1.21
150044	1.60
150045	1.05
150046	1.76
150047	1.24
150049	1.19
150050	1.33
150051	1.48
150052	1.40
150053	1.45
150054	1.11
150056	1.94
150057	2.23
150058	1.77
150059	1.45
150060	0.96
150061	1.55
150062	1.22
150063	1.01
150064	1.23
150065	1.50
150066	1.04
150067	1.34
150069	1.92
150070	1.15
150071	1.01
150072	1.32
150073	1.14
150074	1.67
150075	1.54
150076	1.45
150078	1.20
150079	1.08
150084	2.25
150089	1.72
150090	1.23
150091	1.20
150092	1.20
150094	1.41
150095	1.42

Note: The median service mix for all hospitals is 1.45

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
150096	1.49
150097	1.54
150098	1.19
150099	1.55
150101	1.40
150102	1.08
150103	0.99
150104	1.30
150105	1.19
150106	1.13
150109	2.13
150110	1.04
150111	1.06
150112	2.02
150113	1.59
150114	1.11
150115	2.08
150122	1.50
150123	0.82
150124	1.12
150125	1.62
150126	1.68
150127	0.82
150128	1.69
150129	1.59
150130	0.69
150132	1.73
150133	1.56
150134	1.14
150136	1.54
152007	0.40
152009	0.65
153025	1.30
153027	1.28
153029	0.87
153030	1.06
154009	1.02
154011	1.10
154013	0.93
154014	0.89
154026	0.93
154027	1.01
154028	0.89
154031	0.92
154032	1.07
154035	0.99
154036	0.78
154037	0.93
154038	0.92
154042	0.99
160001	1.86
160002	2.59
160003	1.15
160005	1.83
160007	0.76
160008	1.41
160009	1.01
160012	0.99
160013	1.50
160014	1.94
160016	1.77
160018	1.11
160020	1.14
160021	1.75
160023	1.50
160024	2.22
160026	1.26
160027	1.30
160028	1.42
160029	2.17
160030	2.48
160031	1.04
160032	1.53
160033	2.49
160034	1.58
160035	0.68

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
160036	1.83
160037	1.48
160039	1.55
160040	1.93
160041	0.99
160043	1.21
160044	1.78
160045	1.77
160046	1.83
160047	1.49
160048	1.01
160049	0.74
160050	1.60
160051	2.00
160052	1.25
160054	1.08
160055	1.26
160056	1.13
160057	1.88
160058	1.21
160060	1.24
160061	1.23
160062	1.09
160063	1.20
160064	3.23
160065	1.09
160066	1.68
160067	1.71
160068	1.47
160069	1.99
160070	1.20
160072	1.42
160073	0.85
160074	0.98
160075	1.08
160076	1.45
160077	1.08
160079	4.24
160080	1.87
160081	1.81
160082	2.11
160083	2.02
160085	1.01
160086	0.88
160088	1.24
160089	1.76
160090	1.12
160091	1.11
160092	1.24
160093	0.88
160094	1.41
160095	1.21
160097	1.19
160098	1.01
160099	1.09
160101	0.81
160102	2.26
160103	0.84
160104	1.48
160106	1.80
160107	1.18
160108	1.50
160109	1.04
160110	1.40
160111	1.08
160112	1.94
160113	0.87
160114	1.70
160115	1.35
160116	1.29
160117	1.96
160118	1.15
160120	0.60
160122	1.26
160124	1.42
160126	1.34

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
160129	1.50
160130	1.11
160131	1.01
160134	0.78
160135	2.27
160138	1.07
160140	1.12
160142	0.86
160143	1.18
160145	1.07
160146	2.30
160147	1.32
160151	1.13
160152	1.09
160153	1.92
164002	1.50
164003	0.55
170001	3.46
170004	1.09
170006	1.76
170008	4.11
170009	1.24
170010	1.50
170012	2.13
170013	2.22
170014	1.45
170015	1.20
170016	1.74
170017	1.87
170018	0.91
170019	1.59
170020	2.78
170022	1.64
170023	4.37
170024	1.11
170025	1.09
170026	1.87
170027	1.94
170030	0.97
170031	1.18
170032	0.91
170033	2.77
170034	1.32
170035	0.94
170036	0.68
170037	2.66
170038	0.68
170039	0.88
170040	1.73
170041	1.10
170043	0.67
170044	1.02
170045	2.01
170049	2.05
170051	0.69
170052	0.96
170053	0.68
170054	0.95
170055	0.89
170056	0.66
170057	1.15
170058	2.03
170060	1.24
170061	1.30
170063	0.91
170064	1.04
170066	0.70
170067	1.30
170068	3.21
170070	1.46
170072	0.79
170073	0.79
170074	1.39
170075	0.68
170076	1.36
170077	1.25

Note: The median service mix for all hospitals is 1.45

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
170079	0.97
170080	1.00
170081	0.97
170082	1.22
170084	0.96
170085	1.09
170086	3.87
170088	0.80
170089	0.78
170090	0.75
170092	0.90
170093	0.96
170094	0.95
170095	1.45
170097	1.17
170098	2.04
170099	1.52
170100	0.48
170101	0.93
170102	1.64
170103	2.21
170104	2.49
170105	1.25
170106	0.69
170109	1.09
170110	1.13
170112	0.78
170113	1.24
170114	1.55
170115	1.16
170116	1.58
170117	0.61
170119	0.91
170120	1.91
170122	1.84
170123	2.08
170124	1.58
170126	0.71
170128	1.27
170131	1.23
170133	8.93
170134	0.95
170137	1.88
170139	0.54
170142	2.10
170143	1.98
170144	2.15
170145	3.14
170146	1.47
170147	0.99
170148	1.87
170150	1.96
170151	1.23
170152	0.84
170160	0.91
170164	1.11
170166	0.85
170168	0.81
170171	0.92
170175	2.07
170176	2.23
170182	2.39
171304	0.55
171305	0.25
172004	0.52
173025	0.92
173026	1.13
173027	1.39
173028	1.31
174003	1.04
174006	0.58
174012	0.87
174014	1.08
174015	0.86
174016	0.98
174018	0.88

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
180001	1.55
180004	1.47
180005	1.38
180006	0.81
180007	2.08
180009	1.91
180010	2.00
180011	1.61
180012	2.05
180013	1.84
180014	2.28
180015	1.36
180016	1.56
180017	1.73
180018	1.84
180019	2.09
180021	1.44
180023	1.17
180024	1.41
180025	1.90
180026	1.32
180027	1.97
180030	1.02
180031	0.96
180032	0.86
180033	1.17
180034	1.28
180035	1.57
180036	1.89
180037	1.79
180038	1.35
180040	2.44
180041	1.25
180042	1.35
180043	1.04
180044	1.58
180045	1.77
180046	1.53
180047	1.06
180048	1.79
180049	1.54
180051	1.93
180053	1.34
180054	1.58
180055	2.20
180056	1.65
180058	0.89
180059	1.06
180060	0.55
180063	0.89
180064	1.83
180065	0.81
180066	1.80
180067	1.70
180070	1.31
180072	1.54
180075	1.14
180078	1.33
180079	1.13
180080	2.64
180087	2.13
180088	2.47
180092	1.45
180093	1.89
180094	1.01
180095	1.17
180099	1.18
180101	1.10
180102	2.26
180103	1.89
180104	2.18
180105	1.08
180106	0.94
180108	0.85
180115	1.05
180116	1.57

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
180117	1.65
180118	1.01
180120	1.03
180121	1.56
180122	1.08
180123	1.82
180124	2.10
180126	1.02
180127	1.79
180128	1.58
180129	1.05
180130	2.45
180132	1.90
180133	1.57
180134	1.10
180136	3.09
180137	1.26
180138	1.56
180139	1.29
180140	0.76
183026	0.71
183027	0.94
183028	0.94
183029	0.37
184000	0.97
184002	0.54
184007	0.87
184008	1.77
184009	0.89
184011	0.90
184015	0.58
184016	0.87
190002	1.76
190003	1.31
190004	1.85
190007	1.13
190008	1.93
190013	1.52
190014	1.54
190015	1.47
190017	1.17
190018	1.33
190019	1.55
190020	1.59
190025	1.27
190026	1.50
190027	1.39
190029	1.12
190033	0.71
190034	1.07
190035	1.77
190036	2.07
190037	0.69
190039	1.30
190040	1.94
190041	1.62
190043	0.48
190044	1.38
190045	1.44
190046	1.19
190048	0.84
190049	1.65
190050	1.41
190053	1.19
190054	1.46
190059	1.10
190060	1.70
190064	2.05
190065	1.40
190071	0.99
190077	0.58
190078	1.81
190079	1.14
190081	0.70
190083	0.87
190086	1.98

Note: The median service mix for all hospitals is 1.45

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
190088	1.12
190089	0.98
190090	1.16
190092	1.37
190095	1.18
190098	1.05
190099	0.91
190102	2.37
190103	0.64
190106	1.16
190109	1.03
190110	1.03
190111	1.93
190112	2.34
190113	1.92
190114	0.99
190115	3.87
190116	1.61
190118	1.14
190120	0.90
190124	1.74
190125	1.51
190128	1.55
190130	0.96
190131	1.04
190133	0.92
190134	0.76
190135	1.81
190136	0.66
190138	5.44
190140	1.22
190142	0.67
190144	1.96
190145	0.95
190146	1.30
190147	1.09
190148	0.73
190149	1.02
190151	1.27
190152	1.81
190155	0.92
190156	0.64
190158	1.34
190160	1.79
190162	1.18
190164	2.12
190167	1.08
190170	0.74
190173	1.39
190175	1.34
190176	1.15
190177	2.05
190178	0.74
190182	2.60
190184	0.76
190185	1.59
190186	0.70
190189	0.62
190190	1.14
190191	1.41
190196	1.97
190197	1.71
190200	1.62
190201	1.49
190202	1.66
190203	1.94
190204	1.60
190205	1.77
190206	1.40
190207	2.12
190208	0.72
190218	1.79
190231	3.50
192004	0.83
192005	0.84
192006	1.19

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
192008	0.69
192016	3.00
193027	1.10
193028	1.15
193034	0.80
193038	1.02
193041	0.54
193044	1.63
193300	0.94
194000	1.52
194004	0.83
194014	0.88
194018	0.87
194019	0.73
194020	0.25
194021	0.77
194022	0.72
194023	0.77
194024	1.12
194027	0.82
194029	0.87
194031	0.91
194044	0.86
194058	0.87
200001	1.86
200002	1.40
200003	1.19
200006	0.83
200007	1.15
200008	1.81
200009	1.54
200012	1.32
200013	1.34
200015	1.44
200016	1.20
200017	2.09
200018	1.43
200019	1.47
200020	1.45
200021	1.86
200023	0.74
200024	1.69
200025	1.55
200026	1.22
200027	1.72
200028	1.17
200031	1.22
200032	1.35
200033	1.44
200034	1.84
200037	1.30
200038	1.53
200039	1.59
200040	1.69
200041	1.47
200043	0.84
200050	1.86
200051	1.71
200052	1.16
200055	0.96
200062	0.94
200063	2.11
200066	1.38
203025	0.94
204005	0.97
204006	0.87
204007	0.49
213027	1.00
213028	3.29
214000	0.87
214003	0.90
214013	0.87
214015	0.83
214017	0.92
220001	1.47
220003	1.33

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
220004	1.42
220006	1.58
220008	1.28
220010	2.11
220011	1.11
220015	1.44
220016	1.36
220017	1.49
220019	1.54
220020	1.20
220021	1.39
220023	1.35
220024	1.57
220025	1.72
220028	1.32
220029	1.37
220030	1.00
220031	1.23
220033	1.41
220035	1.51
220036	1.34
220038	1.34
220041	1.44
220042	1.41
220046	1.76
220049	1.91
220050	1.43
220051	1.80
220052	1.45
220053	1.41
220055	1.70
220057	1.47
220058	1.25
220060	1.45
220062	0.92
220063	1.65
220064	1.49
220065	1.24
220066	1.70
220067	1.44
220068	0.85
220070	1.21
220071	1.29
220073	1.37
220074	1.34
220075	1.85
220076	1.30
220077	1.46
220079	1.18
220080	1.35
220081	2.37
220082	1.52
220083	1.63
220084	1.85
220086	1.38
220088	1.44
220089	1.39
220090	1.30
220092	1.36
220094	1.34
220095	1.31
220098	1.49
220100	1.35
220101	1.46
220104	1.01
220105	1.39
220106	1.45
220107	1.50
220108	1.76
220111	1.69
220116	1.19
220119	1.29
220123	1.94
220126	1.54
220128	1.33
220135	1.30

Note: The median service mix for all hospitals is 1.45

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
220153	0.58
220154	1.12
220163	1.16
220171	1.19
222000	0.87
222002	0.71
222006	1.00
222008	0.64
222023	0.86
222024	1.89
222026	0.79
222027	0.64
222029	0.75
222035	0.82
222043	0.55
222044	1.06
222045	3.55
223026	0.79
223027	0.90
223028	1.40
223029	0.74
223030	0.98
223302	1.52
224007	0.92
224013	0.97
224018	0.89
224021	0.89
224022	0.96
224023	0.46
224029	0.86
224034	0.95
224035	1.00
230001	1.47
230002	2.51
230003	1.26
230004	1.78
230005	1.49
230006	1.28
230007	1.78
230012	0.78
230013	1.37
230015	1.42
230017	1.83
230019	1.92
230020	2.00
230021	1.92
230022	1.70
230024	1.81
230027	1.15
230029	1.78
230030	1.90
230031	1.49
230032	2.24
230034	1.35
230035	1.44
230036	1.67
230037	1.56
230038	2.19
230040	1.53
230041	1.71
230042	1.24
230046	1.34
230047	1.99
230053	0.96
230054	1.81
230055	1.38
230056	1.15
230058	1.64
230059	2.18
230060	1.51
230062	1.07
230063	1.54
230065	1.90
230066	1.70
230068	1.71
230069	1.27

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
230070	2.18
230071	7.65
230072	1.47
230075	1.75
230076	3.06
230077	2.07
230078	1.39
230080	1.87
230081	1.68
230082	1.20
230085	2.54
230086	1.11
230087	1.49
230089	1.65
230092	1.51
230093	1.78
230095	1.72
230096	1.52
230097	2.13
230099	1.46
230100	1.27
230101	1.47
230103	1.38
230104	1.52
230105	2.40
230106	1.26
230107	0.91
230108	1.60
230110	1.73
230111	1.17
230113	0.81
230114	5.22
230115	1.11
230116	1.29
230117	1.67
230118	1.55
230119	1.44
230120	1.61
230121	1.75
230122	2.20
230124	1.31
230125	1.19
230128	1.62
230129	1.63
230130	2.06
230132	1.49
230133	1.48
230134	1.63
230135	1.52
230137	1.52
230141	1.56
230142	1.31
230143	1.63
230144	1.68
230145	1.55
230146	1.30
230147	1.26
230149	1.06
230151	1.31
230153	1.37
230154	0.97
230155	1.08
230156	1.52
230157	1.89
230159	1.95
230162	0.76
230165	2.29
230167	1.77
230169	1.80
230171	1.00
230172	1.21
230174	1.44
230175	0.83
230176	1.98
230178	1.16
230180	1.27

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
230184	3.32
230186	1.14
230188	1.49
230189	0.87
230190	0.81
230191	1.28
230193	1.40
230194	0.77
230195	1.92
230197	2.26
230199	1.41
230201	1.62
230204	1.54
230205	1.56
230207	1.33
230208	1.41
230211	0.63
230212	1.34
230213	0.90
230216	1.34
230217	1.43
230219	1.22
230221	1.32
230222	1.85
230223	1.88
230227	1.86
230230	1.90
230232	0.74
230235	1.34
230236	1.93
230239	1.53
230241	1.51
230244	1.80
230253	1.49
230254	1.85
230257	3.48
230259	1.76
230264	2.51
230269	1.97
230270	2.14
230273	1.30
230275	1.19
230276	0.72
230277	1.59
230278	1.19
230279	0.90
230280	1.39
233025	0.89
233026	0.79
233027	0.92
233028	1.02
233300	2.34
234006	1.00
234011	0.92
234021	0.71
234023	0.96
234029	0.88
234030	1.86
240001	2.47
240002	1.93
240004	0.93
240005	0.74
240006	1.80
240007	1.63
240008	1.94
240009	0.99
240010	2.46
240011	2.02
240013	1.40
240014	1.40
240016	1.95
240017	2.36
240018	2.14
240019	1.84
240020	1.25
240021	1.27

Note: The median service mix for all hospitals is 1.45

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
240022	1.34
240023	1.35
240025	1.23
240027	1.94
240028	1.28
240029	1.86
240030	2.15
240031	1.28
240036	1.67
240037	1.16
240038	1.95
240040	1.51
240041	1.38
240043	2.18
240044	1.64
240045	1.77
240047	2.26
240048	2.67
240049	1.24
240050	1.79
240051	1.75
240052	1.46
240053	2.00
240056	2.27
240057	1.55
240058	1.01
240059	2.57
240061	4.46
240063	1.85
240064	2.03
240065	1.13
240066	2.49
240069	2.04
240071	1.73
240072	1.77
240073	1.05
240075	1.69
240076	1.69
240077	1.50
240078	2.33
240079	0.99
240080	1.36
240082	1.19
240083	1.40
240084	1.54
240085	0.88
240086	1.32
240087	1.24
240088	1.28
240089	0.91
240090	2.46
240093	1.69
240094	1.12
240096	0.90
240097	3.54
240098	1.21
240099	1.17
240100	1.99
240101	1.25
240102	0.96
240103	1.07
240104	1.64
240105	0.74
240106	0.98
240107	1.22
240108	1.58
240109	1.21
240110	1.50
240111	1.44
240112	1.29
240114	1.11
240115	1.86
240116	1.25
240117	0.88
240119	0.75
240121	1.42

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
240122	1.00
240123	1.29
240124	1.40
240125	1.17
240127	1.02
240128	2.03
240129	1.41
240130	1.68
240132	1.77
240133	2.16
240135	0.55
240137	2.27
240138	0.98
240139	1.39
240141	1.52
240142	1.16
240143	1.24
240144	1.74
240145	0.93
240146	1.44
240148	0.93
240150	0.78
240152	1.65
240153	1.16
240154	1.13
240155	1.48
240157	1.80
240160	1.39
240161	0.99
240162	1.47
240163	1.20
240166	2.19
240169	1.46
240170	1.11
240171	1.72
240172	1.14
240173	1.58
240179	0.98
240184	1.24
240187	2.12
240193	1.36
240196	9.90
240200	0.61
240207	1.76
240210	1.90
240211	0.68
242004	0.77
243300	0.93
243302	6.10
244009	2.18
250001	1.60
250002	1.01
250003	0.68
250004	1.91
250005	0.71
250006	1.39
250007	1.33
250008	0.68
250009	2.02
250010	0.91
250012	0.85
250015	1.43
250017	0.84
250018	0.44
250019	1.59
250020	0.87
250021	0.53
250023	0.47
250024	0.59
250025	1.29
250027	1.13
250029	0.99
250030	0.74
250031	2.64
250032	1.28
250033	1.04

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
250034	2.16
250035	1.09
250036	1.21
250037	0.98
250038	0.83
250039	0.68
250040	1.66
250042	1.50
250043	1.13
250044	1.23
250045	1.10
250047	0.61
250048	2.62
250049	0.80
250050	1.38
250051	0.75
250057	1.64
250058	1.91
250059	1.35
250060	0.68
250061	0.93
250063	0.88
250065	0.92
250066	0.75
250067	0.92
250068	1.01
250069	2.29
250071	0.78
250072	1.58
250076	0.46
250077	0.91
250078	1.77
250079	0.81
250081	2.72
250082	1.70
250083	0.86
250084	1.93
250085	0.96
250088	1.12
250089	1.05
250093	1.16
250094	2.41
250095	1.56
250096	1.33
250097	1.88
250098	0.73
250099	2.48
250100	1.57
250101	0.73
250102	1.84
250104	2.12
250105	0.86
250107	0.79
250109	0.75
250112	0.85
250117	0.86
250119	1.04
250120	1.42
250122	1.74
250123	1.90
250124	0.83
250125	1.53
250126	0.83
250128	1.14
250131	0.93
250134	0.63
250136	2.86
250138	2.95
250141	1.97
250144	0.55
250145	0.85
250146	0.81
250148	1.26
250149	0.80
252003	0.32
253025	1.39

Note: The median service mix for all hospitals is 1.45

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
254001	0.81
254002	0.80
254006	0.94
260001	1.38
260002	1.40
260003	1.05
260004	0.88
260005	1.66
260006	1.88
260007	1.83
260008	0.82
260009	1.81
260011	1.67
260012	1.14
260013	1.37
260014	1.86
260015	1.41
260017	1.84
260018	0.69
260019	1.11
260020	2.06
260021	1.44
260022	1.43
260023	1.77
260024	1.06
260025	2.36
260027	1.54
260029	1.33
260030	0.75
260031	1.66
260032	1.73
260034	1.13
260035	0.87
260036	1.26
260039	0.91
260040	1.50
260042	1.10
260044	1.10
260047	1.37
260048	1.43
260050	1.51
260052	1.62
260053	1.26
260054	1.57
260055	0.95
260057	1.30
260059	1.16
260061	1.57
260062	1.52
260063	1.31
260064	1.66
260065	1.34
260066	1.25
260067	0.80
260068	1.63
260070	0.94
260073	0.97
260074	1.16
260077	2.07
260078	1.49
260079	0.91
260080	1.18
260081	1.66
260082	1.00
260085	1.73
260086	1.17
260091	2.45
260094	1.63
260095	1.42
260096	1.53
260097	2.58
260100	1.09
260102	0.79
260103	1.20
260104	1.54
260105	1.75

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
260107	2.14
260108	1.39
260109	1.20
260110	1.85
260113	1.47
260115	1.07
260116	1.68
260119	1.64
260120	1.62
260122	1.18
260123	0.90
260127	0.99
260128	0.88
260129	1.28
260131	1.27
260134	1.52
260137	2.07
260138	1.71
260141	1.25
260142	1.96
260143	0.82
260147	0.96
260148	0.92
260158	1.11
260159	1.50
260160	0.95
260162	1.90
260163	1.08
260164	1.19
260166	1.39
260172	1.20
260173	0.79
260175	1.79
260176	1.68
260177	1.92
260178	2.47
260179	1.50
260180	1.46
260183	2.01
260186	1.55
260188	1.53
260189	0.57
260190	1.81
260191	1.68
260193	1.97
260195	1.26
260197	1.77
260198	1.52
260200	1.27
262001	0.66
262011	0.58
263025	1.28
263026	1.15
263300	2.18
263301	1.21
263302	1.23
264005	0.83
264007	0.82
264008	0.82
264010	0.65
264011	1.18
264013	0.87
264015	0.91
264016	2.03
264017	1.17
264021	0.69
264024	0.87
264025	0.78
264026	0.87
270002	1.64
270003	1.63
270004	1.74
270006	0.43
270007	0.70
270009	0.97
270011	1.46

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
270012	2.09
270013	1.84
270014	2.23
270016	0.77
270017	1.27
270019	0.73
270021	1.21
270023	2.07
270024	0.63
270026	1.43
270027	0.93
270028	1.70
270029	1.26
270032	2.60
270033	0.61
270035	1.00
270036	0.85
270039	1.20
270040	1.45
270041	0.89
270044	1.42
270046	0.77
270048	1.75
270049	1.27
270050	1.18
270051	1.78
270052	0.67
270053	0.60
270057	1.54
270058	0.85
270059	0.49
270060	0.61
270063	0.77
270068	1.19
270072	0.43
270073	0.72
270079	1.16
270080	1.30
270081	0.65
270082	0.70
270083	0.89
270084	1.09
271225	0.49
271226	0.69
271227	0.50
271228	0.57
271229	0.67
271230	0.56
271231	0.67
271232	0.60
271233	0.61
280001	1.33
280003	2.35
280005	1.63
280009	2.17
280010	0.77
280011	1.58
280012	1.24
280013	1.41
280014	1.15
280015	1.48
280017	1.18
280018	1.13
280020	1.31
280021	1.75
280022	0.95
280023	1.19
280024	0.92
280025	0.75
280026	0.97
280028	2.02
280029	0.84
280030	1.72
280031	1.45
280032	1.81
280033	0.98

Note: The median service mix for all hospitals is 1.45

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
280034	1.65
280035	1.17
280037	1.01
280038	1.28
280039	1.56
280040	2.07
280041	0.95
280042	0.79
280043	2.09
280045	1.15
280046	1.06
280047	1.68
280048	1.22
280049	0.89
280050	1.16
280051	1.45
280052	1.44
280054	1.15
280055	0.84
280056	0.96
280057	1.45
280058	2.18
280060	1.30
280061	2.55
280062	2.96
280064	1.28
280065	1.88
280066	1.26
280068	0.87
280070	1.30
280073	1.10
280074	1.85
280075	2.00
280076	1.60
280077	2.48
280079	0.82
280080	1.19
280081	1.58
280082	0.87
280083	1.34
280084	1.01
280085	1.66
280088	2.74
280089	1.45
280090	0.72
280091	3.55
280092	0.98
280094	1.36
280097	1.08
280098	0.71
280101	0.73
280102	1.00
280104	1.38
280105	1.67
280106	1.22
280107	1.16
280108	5.55
280109	0.77
280110	1.50
280111	1.21
280114	0.89
280115	2.12
280117	1.72
280118	1.01
283025	0.66
283301	1.10
284007	1.47
290001	1.46
290002	0.51
290003	1.81
290005	2.49
290006	1.10
290007	1.00
290008	1.34
290009	1.40
290010	1.10

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
290011	0.79
290012	1.49
290013	0.59
290014	1.16
290015	0.88
290016	1.11
290019	1.56
290020	0.59
290021	1.46
290022	1.97
290027	0.84
290032	1.28
290038	1.08
292002	0.76
293027	0.96
294003	0.73
294004	0.78
294005	0.89
300001	1.67
300003	1.26
300005	1.56
300006	1.26
300007	1.57
300008	1.76
300009	1.23
300010	1.01
300011	1.75
300012	1.39
300013	1.07
300014	1.51
300015	1.57
300016	1.29
300017	1.43
300018	1.63
300019	1.64
300021	1.18
300022	1.75
300023	1.29
300024	1.46
300028	1.23
300029	2.12
300033	0.98
300034	1.66
303026	1.26
303027	1.00
304000	0.55
304001	7.13
304003	0.87
310001	1.58
310002	1.44
310005	1.62
310006	1.84
310008	2.66
310009	1.69
310010	1.36
310011	2.11
310012	2.19
310013	1.53
310014	1.69
310015	1.58
310016	1.81
310017	2.03
310018	1.76
310019	1.84
310020	1.87
310021	1.60
310022	1.72
310024	2.26
310025	1.84
310026	1.64
310027	1.62
310028	1.67
310029	2.82
310031	1.35
310032	1.65
310034	2.02

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
310036	1.44
310037	1.64
310039	2.07
310041	1.66
310042	1.68
310043	1.86
310044	1.53
310045	1.87
310047	2.07
310048	1.87
310050	1.25
310051	1.99
310052	1.53
310054	1.63
310056	1.12
310057	1.66
310058	0.83
310060	2.12
310061	1.95
310062	1.24
310063	1.90
310064	1.78
310067	1.73
310069	1.69
310070	1.96
310072	2.01
310073	1.63
310074	0.97
310076	1.38
310077	1.79
310078	1.45
310081	1.90
310083	1.00
310084	1.44
310086	1.58
310087	1.49
310088	1.28
310090	2.02
310091	2.12
310092	1.63
310093	1.61
310096	1.97
310105	1.06
310108	1.74
310111	1.49
310112	1.91
310113	1.77
310115	1.30
310116	1.65
310118	1.48
310120	1.25
312014	0.70
313025	0.95
313026	0.91
313027	0.99
313029	1.05
313030	0.78
313300	0.90
314001	1.00
314010	0.88
314011	0.89
314012	1.07
314021	0.91
314022	0.87
320001	0.97
320002	1.15
320003	1.52
320004	1.64
320005	1.85
320006	1.73
320009	1.59
320011	1.16
320012	1.48
320013	1.35
320014	1.02
320016	1.91

Note: The median service mix for all hospitals is 1.45

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
320017	1.31
320018	2.01
320019	0.80
320021	1.21
320022	1.76
320023	0.81
320030	1.17
320031	0.74
320032	0.91
320033	1.53
320035	0.72
320037	1.40
320038	1.46
320046	1.20
320048	0.91
320063	1.46
320065	1.32
320067	0.77
320068	0.91
320069	1.25
320074	1.31
320079	1.47
322002	1.31
322003	0.52
323025	0.92
323026	0.74
323027	0.92
323028	1.09
323029	0.87
324003	0.88
324004	0.87
324007	0.97
324008	0.98
324010	1.10
330001	1.68
330002	1.49
330003	1.56
330004	1.59
330005	1.62
330006	1.50
330007	1.54
330008	1.46
330010	1.38
330011	1.13
330012	1.47
330013	1.91
330014	1.26
330016	1.28
330020	0.84
330023	1.68
330024	1.55
330025	1.25
330027	0.61
330028	1.15
330029	1.05
330030	1.58
330033	1.02
330034	0.71
330036	1.57
330037	1.58
330038	1.23
330039	0.72
330041	2.14
330043	1.30
330044	1.61
330045	2.04
330046	1.31
330047	1.51
330048	1.78
330049	1.62
330053	1.20
330055	1.71
330056	1.29
330057	1.64
330058	1.40
330059	1.44

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
330061	2.02
330062	0.92
330064	1.55
330065	1.65
330066	1.43
330067	1.75
330072	1.25
330073	1.30
330074	1.88
330075	1.32
330078	1.32
330079	1.38
330084	1.35
330085	1.19
330086	1.28
330088	1.15
330090	1.59
330091	1.53
330092	0.88
330094	1.27
330095	1.62
330096	1.49
330097	1.15
330100	3.05
330101	1.52
330102	1.90
330103	1.90
330104	1.44
330106	1.88
330107	1.75
330108	1.49
330111	1.34
330114	0.59
330115	1.59
330116	1.23
330118	1.68
330119	1.86
330121	0.87
330122	1.79
330125	1.31
330126	1.64
330132	0.98
330133	1.96
330135	1.56
330136	0.84
330140	1.72
330141	1.59
330144	1.48
330148	1.09
330151	1.30
330152	1.71
330153	1.51
330157	1.28
330158	1.69
330159	1.59
330160	1.40
330161	0.87
330162	2.57
330163	1.68
330164	1.28
330166	1.34
330167	2.53
330169	1.43
330171	1.48
330175	1.33
330177	1.24
330179	0.84
330180	1.26
330181	1.54
330182	2.51
330183	1.28
330184	1.53
330185	1.11
330188	1.66
330189	5.26
330191	1.48

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
330193	1.70
330194	1.31
330195	1.49
330197	1.45
330198	1.68
330203	2.34
330205	1.39
330208	1.62
330209	1.54
330211	1.34
330212	1.64
330213	1.09
330214	1.82
330215	1.69
330218	1.16
330219	1.23
330221	1.36
330222	1.76
330223	1.29
330224	1.68
330225	1.51
330226	1.50
330229	1.40
330230	1.59
330232	1.38
330233	1.27
330235	1.96
330236	1.37
330238	1.53
330239	1.45
330241	1.63
330242	1.70
330245	1.49
330246	1.67
330247	3.47
330249	1.30
330250	1.51
330252	0.76
330254	1.34
330258	0.96
330259	1.52
330261	1.46
330263	1.76
330264	1.62
330265	1.10
330267	1.43
330268	0.96
330270	1.34
330273	1.63
330275	1.29
330276	1.21
330277	1.72
330279	1.84
330285	1.38
330286	1.62
330288	0.67
330290	1.25
330293	1.10
330304	1.79
330306	1.18
330307	1.80
330308	1.98
330314	1.81
330316	2.02
330327	1.13
330331	1.65
330332	2.55
330333	1.80
330336	1.40
330338	1.79
330339	2.41
330340	1.65
330350	1.42
330353	1.89
330357	1.29
330359	0.65

Note: The median service mix for all hospitals is 1.45

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
330372	1.88
330381	1.26
330386	1.30
330389	1.37
330390	0.94
330393	1.81
330394	1.59
330395	1.55
330397	0.96
330398	2.02
330399	0.88
332012	0.83
332021	0.53
332022	0.77
333025	0.77
333027	0.80
333028	0.72
333300	1.34
334002	0.87
334022	0.89
334023	1.10
334027	0.75
334048	1.30
334049	0.86
334055	0.83
340001	1.24
340002	2.20
340003	1.37
340004	1.79
340005	1.28
340006	0.92
340007	1.18
340008	1.44
340009	11.22
340010	1.92
340011	1.10
340012	1.45
340013	1.29
340014	0.99
340015	1.80
340016	1.99
340017	1.77
340018	1.40
340019	1.06
340020	1.31
340021	1.63
340022	1.20
340023	1.19
340024	1.41
340025	1.78
340027	1.94
340028	1.49
340030	1.51
340031	1.22
340032	1.67
340035	1.51
340036	1.05
340037	1.16
340038	2.00
340039	1.70
340040	1.99
340041	1.27
340042	1.29
340044	1.03
340045	0.69
340047	1.56
340049	4.05
340050	2.52
340051	1.76
340052	1.21
340053	2.01
340054	1.46
340055	1.23
340060	1.43
340061	1.19
340063	0.85

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
340064	1.36
340065	1.21
340067	1.46
340068	1.62
340069	1.54
340070	1.62
340071	1.21
340072	1.47
340073	1.93
340075	1.27
340080	1.07
340084	0.91
340085	1.49
340087	1.16
340088	1.73
340089	0.95
340090	1.30
340091	1.97
340093	1.10
340094	2.16
340096	1.65
340097	1.61
340098	1.74
340099	1.19
340100	0.55
340101	1.49
340104	1.12
340105	2.59
340106	1.25
340107	1.87
340109	2.34
340111	1.41
340112	1.15
340113	1.55
340114	1.32
340115	1.50
340116	1.75
340119	1.39
340120	1.17
340121	1.35
340123	1.38
340124	1.22
340125	2.53
340126	1.71
340127	1.20
340129	1.60
340130	1.69
340131	1.74
340132	1.29
340133	0.94
340141	1.78
340142	1.33
340143	1.72
340144	1.88
340145	1.56
340146	0.80
340147	1.96
340148	2.81
340151	1.53
340153	2.63
340155	1.59
340158	1.75
340159	0.93
340160	1.50
340162	1.08
340164	1.23
340166	1.28
340171	1.65
342003	1.01
342012	0.55
343025	1.00
344005	0.87
344006	0.87
344010	0.68
344011	1.01
344014	1.08

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
344015	0.87
344016	0.72
344019	0.87
350001	0.71
350002	2.20
350003	1.45
350004	2.27
350005	1.22
350006	1.32
350007	1.37
350008	1.11
350009	1.85
350010	1.32
350011	1.84
350012	1.09
350013	1.12
350014	1.20
350015	2.07
350016	0.69
350017	1.48
350018	1.45
350019	2.12
350020	0.83
350021	1.08
350023	1.43
350024	1.19
350025	0.90
350027	0.68
350029	0.88
350030	1.44
350033	1.32
350034	1.21
350035	0.56
350038	1.80
350039	1.23
350041	0.93
350042	1.75
350043	1.74
350044	1.10
350047	1.11
350049	1.43
350050	0.91
350051	1.04
350053	0.86
350055	0.81
350056	1.24
350058	1.02
350060	0.54
350061	1.54
360001	1.79
360002	1.50
360003	1.29
360006	2.02
360007	1.28
360008	1.36
360009	1.56
360010	1.64
360011	1.33
360012	1.89
360013	1.36
360014	1.63
360016	1.27
360017	2.64
360018	1.57
360019	1.38
360020	1.41
360021	3.45
360024	1.47
360025	1.10
360026	1.38
360027	1.68
360028	2.30
360029	1.62
360030	1.48
360031	1.34
360032	1.62

Note: The median service mix for all hospitals is 1.45

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
360034	0.96
360035	1.31
360036	1.55
360037	1.35
360038	1.43
360039	1.36
360040	1.24
360041	1.46
360042	1.24
360044	1.56
360045	1.24
360046	1.51
360047	0.97
360048	1.57
360049	1.60
360050	1.00
360051	1.96
360052	1.45
360054	1.69
360055	1.66
360056	1.67
360057	1.10
360058	1.19
360059	1.11
360062	1.69
360063	1.09
360064	2.07
360065	1.42
360066	1.64
360067	1.06
360068	1.53
360069	1.18
360070	1.23
360071	1.40
360072	1.47
360074	1.46
360075	1.50
360076	1.68
360077	1.61
360078	1.46
360079	1.80
360080	1.36
360081	1.53
360082	1.83
360083	1.53
360084	1.70
360085	1.93
360086	1.45
360087	1.48
360088	1.21
360089	1.34
360090	2.29
360091	1.47
360092	1.15
360093	1.93
360094	1.29
360095	1.59
360096	1.41
360098	1.88
360099	1.23
360100	1.62
360101	1.92
360102	1.87
360103	1.39
360106	1.05
360107	1.21
360108	1.11
360109	1.32
360112	1.66
360113	1.58
360114	1.30
360115	1.47
360116	1.07
360118	1.40
360121	1.94
360123	1.42

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
360125	1.13
360126	1.25
360127	1.49
360128	1.04
360129	1.04
360130	1.36
360131	1.46
360132	1.67
360133	1.66
360134	1.63
360136	1.06
360137	1.52
360140	1.02
360141	1.82
360142	1.23
360143	1.50
360144	1.68
360145	1.63
360147	1.54
360148	1.36
360149	1.73
360150	1.77
360151	1.71
360152	1.71
360153	1.10
360154	1.00
360155	1.65
360156	1.42
360159	1.46
360161	1.53
360162	1.42
360163	1.85
360164	1.06
360165	1.00
360166	1.13
360170	1.30
360172	1.72
360174	1.67
360175	1.68
360176	1.14
360177	0.96
360178	1.37
360179	1.51
360180	1.80
360184	0.88
360185	1.41
360186	0.97
360187	1.64
360188	1.03
360189	1.44
360192	1.44
360193	1.52
360194	1.34
360195	1.77
360197	1.19
360200	1.00
360203	1.50
360204	1.26
360210	1.58
360211	1.46
360212	1.50
360213	1.32
360218	1.42
360230	1.87
360231	0.87
360234	1.31
360236	1.58
360239	1.64
360241	0.81
360243	0.87
360244	0.87
360245	0.89
362004	1.18
362007	0.33
362009	0.94
362014	3.41

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
362015	0.99
363300	1.21
363303	1.31
363305	1.22
363306	0.86
364003	0.92
364017	0.85
364026	0.88
364029	0.93
364032	1.09
364038	1.10
370001	1.82
370002	1.98
370004	1.78
370005	0.92
370006	1.53
370007	1.43
370008	1.77
370011	1.12
370012	0.86
370013	1.89
370014	1.59
370015	1.18
370016	1.85
370017	1.20
370018	2.00
370019	1.45
370020	1.40
370021	0.86
370022	2.88
370023	1.43
370025	1.63
370026	1.88
370028	2.09
370029	1.59
370030	1.20
370032	2.50
370033	1.71
370034	1.60
370035	1.26
370036	0.53
370037	2.76
370038	0.96
370039	1.29
370040	2.17
370041	1.09
370042	0.91
370043	0.81
370045	0.98
370046	1.48
370047	1.81
370048	1.13
370049	2.04
370051	0.77
370054	1.70
370056	1.81
370057	1.23
370059	0.65
370060	1.04
370063	0.91
370064	1.03
370065	1.63
370071	0.89
370072	0.88
370076	1.46
370077	1.37
370078	2.17
370079	1.24
370080	1.02
370082	0.89
370083	1.54
370084	1.13
370085	1.07
370086	1.54
370089	1.35
370091	2.03

Note: The median service mix for all hospitals is 1.45

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
370092	1.63
370093	2.42
370094	1.99
370095	0.91
370097	1.46
370099	1.35
370100	0.88
370103	1.08
370105	2.87
370106	2.52
370108	1.02
370112	0.99
370113	1.21
370114	1.91
370121	1.82
370122	0.63
370123	1.81
370125	1.27
370126	0.84
370131	0.85
370133	1.16
370138	1.50
370139	1.03
370140	1.13
370141	1.14
370146	0.87
370148	1.40
370149	1.84
370153	1.69
370154	1.56
370156	1.46
370158	1.38
370159	1.35
370163	0.80
370165	0.99
370166	1.31
370169	1.50
370176	1.65
370177	1.07
370178	1.33
370179	0.90
370183	1.38
370186	1.45
370190	1.66
370192	2.00
372004	0.51
373025	0.97
373026	0.84
374003	0.71
374006	0.79
374008	1.09
374010	0.98
374012	0.88
374013	0.85
374017	0.90
374018	0.68
374019	0.95
374020	0.85
380001	2.38
380002	2.39
380003	2.52
380004	3.35
380005	2.55
380006	1.64
380007	2.26
380008	1.37
380009	1.48
380010	1.45
380011	1.95
380013	1.08
380014	2.43
380017	3.10
380018	1.40
380019	1.26
380020	3.28
380021	2.64

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
380022	2.06
380023	1.47
380025	2.38
380026	1.62
380027	1.58
380029	1.88
380031	1.02
380033	1.81
380035	2.25
380036	1.39
380037	1.74
380038	2.14
380039	1.64
380040	1.76
380042	1.52
380047	2.34
380048	0.72
380050	1.43
380051	1.77
380052	2.78
380056	1.24
380060	1.75
380061	2.66
380062	0.62
380063	1.77
380064	1.51
380065	0.96
380066	2.44
380068	1.03
380069	0.88
380070	1.04
380071	2.13
380072	1.31
380075	1.51
380078	1.14
380081	0.77
380082	2.32
380083	1.63
380084	1.58
380087	0.95
380088	1.55
380089	2.58
380090	1.93
384006	0.90
390001	1.79
390002	1.62
390003	1.11
390004	1.68
390005	1.48
390006	1.17
390007	2.39
390008	1.36
390009	1.68
390010	1.63
390011	1.57
390012	1.81
390013	1.93
390015	1.15
390016	1.43
390017	1.44
390018	1.86
390019	1.37
390022	1.85
390023	1.12
390024	1.99
390025	0.72
390026	1.36
390028	1.98
390029	1.72
390030	1.45
390031	1.55
390032	1.45
390035	1.67
390036	1.75
390037	1.76
390039	1.53

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
390040	1.13
390041	1.81
390042	1.62
390043	1.89
390044	1.76
390045	1.51
390046	1.31
390047	1.65
390048	1.55
390049	1.82
390050	2.01
390051	1.78
390052	1.65
390054	1.35
390055	1.76
390056	1.41
390057	1.67
390058	2.05
390060	1.16
390061	1.56
390062	1.87
390063	2.32
390065	1.63
390066	1.44
390067	1.84
390068	1.27
390069	1.51
390070	2.11
390071	1.61
390072	1.42
390073	1.70
390074	1.74
390075	1.53
390076	1.51
390078	1.74
390079	2.09
390080	1.57
390081	2.02
390083	1.19
390084	1.26
390086	1.57
390088	1.27
390090	1.91
390091	1.44
390093	1.31
390095	1.52
390096	1.46
390097	1.57
390100	1.70
390101	1.24
390102	1.81
390103	1.39
390104	1.26
390106	1.31
390107	1.66
390108	1.54
390109	1.15
390110	1.43
390111	1.36
390112	1.54
390113	1.55
390114	1.64
390115	1.44
390116	1.39
390118	1.85
390119	1.71
390121	1.59
390122	1.47
390123	2.69
390125	1.55
390126	1.77
390127	1.63
390128	1.87
390130	1.35
390131	1.69
390132	1.30

Note: The median service mix for all hospitals is 1.45

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
390133	1.71
390135	1.45
390136	2.33
390137	1.75
390138	1.45
390139	1.64
390142	1.16
390145	1.59
390146	1.37
390147	1.48
390150	1.32
390151	1.58
390152	1.65
390153	1.26
390154	1.82
390155	0.92
390156	2.28
390157	1.60
390158	1.49
390160	1.74
390161	1.69
390162	1.71
390163	1.58
390164	1.52
390166	1.19
390167	1.49
390168	1.50
390169	2.09
390170	1.87
390173	1.63
390174	1.70
390176	1.38
390178	1.69
390179	1.61
390180	1.30
390181	1.56
390183	1.60
390184	1.13
390185	1.87
390189	1.38
390191	1.91
390192	1.44
390193	1.86
390194	1.45
390195	1.85
390197	2.04
390198	1.58
390199	1.12
390200	1.05
390201	1.53
390203	1.75
390204	1.64
390205	1.61
390206	1.43
390209	1.34
390211	1.73
390213	0.70
390215	1.74
390217	1.41
390219	1.21
390220	2.63
390222	1.86
390223	0.85
390224	1.13
390225	1.43
390226	1.54
390228	1.53
390231	1.35
390233	1.41
390235	1.09
390236	1.42
390237	1.45
390238	3.25
390242	1.66
390244	0.64
390245	1.34

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
390246	1.66
390247	0.66
390249	0.72
390256	1.26
390258	1.64
390260	2.34
390262	1.79
390263	1.87
390265	1.06
390266	1.65
390267	1.78
390268	1.70
390270	1.69
390277	0.67
390279	1.54
392024	1.04
392025	1.08
392026	0.75
393025	0.75
393026	1.05
393027	1.41
393031	1.11
393032	0.85
393035	0.67
393037	0.87
393038	1.12
393039	0.93
393040	2.28
393041	1.47
393042	0.92
393043	0.62
393046	0.83
393301	1.27
393302	1.02
394006	0.79
394007	0.48
394008	1.88
394020	0.83
394023	0.77
394027	0.81
394034	0.85
394040	0.78
394041	0.83
394045	0.90
400001	1.10
400002	3.18
400003	0.97
400004	1.33
400005	1.12
400006	1.58
400007	0.76
400009	1.26
400010	0.76
400011	1.43
400012	0.74
400013	0.89
400014	3.08
400016	1.70
400017	1.31
400018	0.90
400019	2.15
400021	1.36
400022	1.25
400026	0.61
400027	0.58
400028	1.08
400029	0.73
400032	0.75
400094	0.74
400098	0.89
400102	1.52
400106	0.99
400109	1.29
400111	0.92
400112	0.70
400113	1.34

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
400114	0.95
400115	0.77
400117	1.34
400118	1.14
400120	1.44
400121	0.50
400122	0.65
400123	2.61
400124	6.42
404002	1.66
410001	1.45
410004	1.61
410005	2.08
410006	1.53
410007	1.72
410008	2.13
410009	2.11
410010	1.54
410011	1.94
410012	1.59
410013	1.81
413025	0.74
414000	1.33
420002	3.24
420004	2.85
420005	2.33
420006	0.86
420007	1.69
420009	1.66
420010	1.55
420011	1.18
420014	0.97
420015	1.61
420016	1.37
420018	1.37
420019	1.88
420020	2.01
420023	2.55
420026	2.05
420027	1.82
420030	1.60
420031	0.91
420033	1.52
420036	2.26
420037	1.41
420038	1.37
420039	1.18
420042	1.17
420043	1.29
420048	1.97
420049	1.93
420051	1.67
420053	1.66
420054	1.21
420055	1.18
420056	1.52
420057	1.16
420059	1.07
420061	1.12
420062	1.73
420064	1.02
420065	1.82
420066	1.27
420067	3.32
420068	1.63
420069	1.19
420070	2.73
420071	1.64
420072	0.83
420073	1.92
420074	0.95
420075	1.39
420078	1.85
420079	1.17
420080	2.72
420081	0.61

Note: The median service mix for all hospitals is 1.45

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
420082	1.81
420083	3.22
420085	2.37
420086	2.02
420087	1.99
420088	1.80
420089	2.68
420091	2.25
423025	1.90
423026	1.11
424006	0.87
424007	0.72
424008	0.88
424009	0.71
424010	0.88
430004	1.41
430005	1.88
430007	2.02
430008	1.54
430010	1.68
430011	2.90
430012	2.09
430013	1.87
430014	1.96
430015	3.56
430016	1.73
430018	0.99
430022	0.75
430023	1.01
430024	0.87
430026	0.95
430027	2.50
430028	1.47
430029	1.47
430031	1.06
430033	1.06
430034	0.94
430036	1.17
430037	2.29
430038	1.49
430040	2.17
430041	0.95
430043	1.53
430044	1.02
430047	1.12
430048	1.57
430049	0.75
430051	0.68
430054	1.45
430056	1.29
430057	1.28
430060	0.62
430062	1.23
430064	0.96
430065	0.83
430066	0.93
430073	1.13
430076	0.74
430077	1.90
430079	0.68
430087	0.73
434004	0.95
440001	1.36
440002	2.61
440003	1.62
440006	1.93
440007	0.72
440008	1.35
440009	2.00
440010	1.16
440011	1.53
440012	1.26
440014	1.03
440015	2.17
440016	1.29
440017	1.59

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
440018	1.04
440019	1.54
440020	1.26
440022	1.03
440023	1.05
440024	1.75
440025	1.42
440026	0.88
440029	1.98
440030	1.74
440031	1.44
440032	0.99
440033	1.22
440034	1.61
440035	1.63
440039	1.45
440040	1.04
440041	0.76
440046	1.52
440047	1.09
440048	2.09
440049	1.66
440050	1.22
440051	1.04
440052	1.02
440053	1.89
440054	1.29
440056	1.12
440057	1.21
440058	1.97
440059	1.63
440060	1.01
440061	1.36
440063	1.59
440064	1.02
440065	1.53
440067	1.46
440068	1.45
440070	1.08
440071	1.63
440072	1.78
440073	1.68
440078	1.04
440081	1.32
440082	1.87
440083	0.79
440084	0.96
440090	0.99
440091	1.79
440100	1.07
440102	1.17
440103	1.50
440104	1.60
440105	3.75
440109	1.05
440110	1.24
440111	0.87
440114	1.25
440115	1.26
440120	2.21
440125	1.87
440130	1.95
440131	1.80
440132	1.41
440133	2.08
440135	1.28
440137	1.29
440141	0.73
440142	0.95
440143	1.07
440144	2.32
440145	0.84
440147	4.16
440148	1.30
440149	0.98
440150	2.08

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
440151	1.31
440152	1.04
440153	1.27
440156	2.55
440157	1.10
440159	1.24
440161	2.26
440162	0.74
440166	1.81
440168	1.27
440173	2.57
440174	1.25
440175	1.48
440176	1.74
440178	1.26
440180	1.16
440181	1.25
440182	1.24
440183	2.93
440184	2.01
440185	1.39
440186	1.27
440187	1.25
440189	2.18
440192	1.07
440193	1.93
440194	1.39
440197	1.71
440200	1.34
440203	1.26
440205	0.92
440206	1.19
442007	0.68
443025	1.05
443026	1.03
443028	1.05
443029	2.01
444003	0.74
444004	0.88
444006	0.89
444010	0.82
444011	0.98
444012	0.94
444017	0.79
444018	0.83
450002	1.37
450004	1.02
450005	1.31
450007	1.80
450008	1.18
450010	1.39
450011	1.44
450014	0.96
450015	0.84
450016	1.80
450018	0.99
450020	1.20
450021	1.24
450023	1.72
450024	1.04
450025	1.49
450028	1.69
450029	1.15
450031	1.27
450032	1.07
450033	1.14
450034	1.59
450035	1.90
450037	1.47
450039	0.74
450040	1.37
450042	1.49
450044	1.46
450046	1.63
450047	1.22
450050	0.80

Note: The median service mix for all hospitals is 1.45

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
450051	1.46
450052	0.80
450053	0.92
450054	1.36
450055	1.00
450056	2.46
450058	1.43
450059	1.65
450063	0.64
450064	1.51
450065	0.74
450068	1.32
450072	1.43
450073	0.88
450078	0.73
450079	1.57
450080	1.86
450081	0.94
450082	0.99
450083	1.67
450085	0.93
450087	1.32
450090	1.47
450092	1.03
450094	2.09
450096	1.59
450097	2.23
450098	0.77
450099	1.43
450101	1.39
450102	1.75
450104	1.30
450107	1.79
450108	0.78
450109	0.94
450110	1.07
450111	1.51
450112	1.74
450113	1.67
450118	2.42
450119	1.55
450121	1.59
450123	0.96
450124	1.26
450126	1.30
450128	1.33
450130	1.72
450131	1.14
450132	1.38
450133	1.41
450135	1.30
450137	1.19
450140	0.82
450142	1.40
450143	0.90
450144	0.80
450145	0.70
450146	0.70
450147	1.34
450148	1.22
450149	1.22
450150	0.74
450151	0.90
450152	1.36
450153	1.40
450154	1.10
450155	0.94
450157	0.75
450160	1.08
450162	1.32
450163	1.06
450164	0.75
450165	1.04
450166	0.60
450169	0.66
450170	0.77

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
450176	1.50
450177	1.22
450178	0.79
450181	0.82
450184	1.43
450185	0.86
450187	1.27
450188	0.97
450190	2.27
450191	1.41
450192	1.17
450193	2.81
450194	1.26
450196	1.57
450200	1.34
450201	1.38
450203	1.10
450209	1.12
450210	0.93
450211	1.61
450214	1.87
450217	0.67
450219	1.28
450221	0.75
450222	1.63
450224	1.28
450229	1.67
450231	1.43
450234	0.82
450235	1.09
450236	1.59
450237	1.07
450239	0.83
450241	0.81
450243	0.74
450246	0.87
450249	0.87
450250	0.83
450253	1.21
450258	0.70
450259	1.80
450264	0.59
450269	0.79
450270	0.77
450271	0.83
450272	1.57
450276	0.75
450278	0.84
450280	1.16
450283	0.87
450286	0.68
450288	0.91
450289	0.73
450292	0.98
450293	1.03
450296	1.38
450299	1.91
450303	0.67
450306	1.14
450307	0.68
450309	0.86
450315	1.51
450320	1.41
450321	0.73
450322	0.73
450324	1.27
450327	0.63
450330	1.08
450334	0.66
450337	0.82
450340	1.59
450341	1.25
450346	1.33
450347	1.24
450348	0.76
450351	1.70

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
450352	1.18
450353	1.02
450355	0.77
450358	1.60
450362	1.27
450369	0.89
450370	1.74
450371	0.93
450372	1.36
450373	0.83
450374	0.67
450376	1.64
450378	1.08
450379	1.35
450381	0.79
450388	2.25
450389	1.49
450393	1.11
450395	0.97
450399	0.66
450400	1.05
450403	1.52
450411	0.91
450417	1.01
450418	1.39
450419	1.01
450422	9.97
450423	1.94
450424	1.76
450429	0.65
450431	1.41
450438	1.10
450446	0.89
450447	1.93
450451	0.79
450457	1.67
450460	1.05
450462	1.17
450464	0.81
450465	1.61
450467	0.95
450469	1.31
450473	0.77
450475	1.24
450484	1.77
450488	1.04
450489	0.64
450497	0.90
450498	1.18
450508	1.26
450514	1.83
450517	0.83
450518	2.02
450523	2.60
450530	1.42
450534	0.71
450535	1.55
450537	1.30
450538	1.15
450539	1.38
450544	1.25
450545	2.33
450547	0.87
450550	1.42
450551	1.40
450558	1.52
450559	0.85
450561	1.38
450563	1.29
450565	1.09
450570	0.93
450571	1.65
450573	0.89
450574	0.57
450575	0.68
450578	0.65

Note: The median service mix for all hospitals is 1.45

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
450580	1.13
450583	0.69
450584	1.00
450586	0.89
450587	1.45
450591	1.31
450596	1.39
450597	0.97
450603	0.70
450604	1.32
450605	1.09
450609	0.74
450610	1.48
450614	0.83
450615	0.77
450617	1.33
450620	0.91
450623	1.31
450626	0.89
450628	0.70
450630	1.39
450631	1.59
450632	0.54
450633	1.56
450634	1.96
450638	2.14
450639	1.42
450641	0.95
450643	1.42
450644	1.81
450646	1.79
450647	1.60
450648	0.94
450649	0.82
450651	1.42
450652	0.68
450653	1.78
450654	0.79
450656	1.58
450658	1.00
450659	2.15
450661	2.36
450662	1.22
450665	0.86
450666	1.39
450668	1.93
450669	1.42
450670	1.64
450672	1.81
450673	0.73
450674	3.52
450675	1.48
450677	1.30
450678	1.51
450683	1.16
450684	1.38
450686	1.46
450688	1.41
450690	0.99
450691	1.19
450694	1.27
450696	6.04
450697	1.28
450698	0.67
450700	0.84
450702	1.53
450703	1.10
450704	1.33
450705	1.17
450706	1.42
450709	2.71
450711	1.87
450712	0.88
450713	1.67
450715	0.98
450716	1.76

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
450717	1.71
450718	1.60
450723	1.31
450724	1.95
450725	1.36
450727	1.06
450728	0.68
450730	1.45
450733	1.59
450735	0.44
450742	1.55
450743	1.60
450746	0.75
450747	1.74
450749	0.74
450750	0.91
450751	1.65
450754	1.07
450755	1.16
450757	0.67
450758	0.90
450760	1.75
450761	0.73
450763	1.30
450766	1.75
450769	0.74
450770	0.90
450771	1.37
450774	3.69
450775	1.81
450776	0.81
450777	0.85
450779	1.20
450780	3.40
450785	10.47
450788	1.26
450795	0.62
450796	10.29
450797	5.76
450798	0.35
450801	1.84
450802	1.60
450803	0.85
450804	3.50
450809	1.95
452013	0.64
452015	0.55
452016	0.55
452019	1.11
452022	1.00
452028	0.32
452033	0.65
452036	0.52
452037	1.39
452038	0.87
452039	0.69
452042	0.31
452043	0.71
452045	1.03
453025	0.88
453028	0.54
453029	1.25
453031	1.04
453032	0.52
453033	0.75
453034	0.67
453035	1.50
453036	1.40
453037	0.81
453038	0.83
453040	0.83
453041	0.59
453042	0.79
453044	0.90
453047	0.78
453048	0.82

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
453052	0.98
453053	0.98
453054	1.08
453055	0.70
453056	1.05
453057	0.90
453059	0.98
453065	2.22
453072	0.61
453300	0.77
453302	0.98
453304	0.93
453305	0.71
454000	0.67
454006	0.59
454008	0.47
454009	0.60
454011	0.54
454012	0.77
454014	0.81
454018	0.89
454026	0.94
454028	0.87
454029	1.31
454030	0.86
454031	0.91
454032	0.88
454037	0.87
454038	0.87
454040	0.83
454042	0.81
454043	0.86
454045	0.88
454046	0.87
454050	0.87
454051	0.87
454056	1.08
454057	0.89
454058	0.87
454060	0.88
454063	0.85
454064	0.87
454065	0.89
454066	0.87
454069	0.96
454072	0.87
454073	0.99
454078	0.79
454083	0.89
454084	0.59
454086	0.96
454089	0.88
460001	1.97
460003	2.18
460004	1.73
460005	1.82
460006	2.28
460007	1.93
460008	1.45
460009	1.82
460010	1.64
460011	1.42
460013	2.16
460014	1.00
460015	1.88
460016	0.97
460017	2.21
460018	1.11
460019	1.13
460020	1.22
460021	1.65
460022	0.82
460023	1.97
460024	0.70
460025	0.49
460026	1.21

Note: The median service mix for all hospitals is 1.45

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
460027	0.97
460029	1.22
460030	1.62
460032	0.90
460033	1.28
460035	0.85
460036	1.20
460037	1.41
460039	0.93
460041	1.69
460042	1.59
460044	1.37
460046	7.81
460047	1.46
460049	7.48
460050	2.50
463025	1.08
463301	1.56
464003	0.87
464007	7.13
464009	0.85
464010	0.87
470001	1.35
470003	1.86
470004	1.06
470005	1.47
470006	1.59
470008	1.34
470010	1.23
470011	1.51
470012	1.99
470015	1.18
470018	1.39
470020	0.78
470023	1.49
470024	1.33
474001	0.72
480001	1.19
480002	1.30
490001	1.29
490002	1.14
490003	10.75
490004	1.69
490005	1.77
490006	1.28
490007	1.74
490009	1.36
490011	1.92
490012	1.02
490013	1.87
490014	2.11
490015	1.98
490017	2.14
490018	1.81
490019	1.46
490020	2.42
490021	2.69
490022	1.61
490023	1.59
490024	1.61
490027	1.31
490030	1.73
490031	1.54
490032	1.29
490033	1.15
490035	1.53
490037	1.63
490038	1.58
490040	2.07
490041	2.03
490042	1.75
490043	1.34
490044	1.62
490045	1.58
490046	2.03
490047	0.96

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
490048	1.75
490050	1.86
490052	1.97
490053	2.23
490054	1.41
490057	1.82
490059	2.24
490060	1.62
490063	2.18
490066	1.89
490067	1.90
490069	1.11
490071	2.06
490073	2.81
490074	2.72
490075	1.83
490077	1.67
490079	1.49
490083	9.68
490084	1.84
490085	1.48
490088	1.64
490089	1.04
490090	1.74
490091	1.84
490092	1.45
490093	1.76
490094	1.43
490095	1.31
490097	1.24
490098	1.45
490099	0.74
490100	2.66
490101	2.21
490107	2.28
490110	2.29
490111	1.53
490112	1.76
490113	1.76
490114	1.12
490115	1.51
490116	1.57
490117	0.88
490118	2.01
490119	1.95
490120	1.62
490122	2.03
490123	1.41
490124	1.50
490126	1.64
490127	0.93
490130	1.61
490131	1.39
492001	0.21
493025	0.87
493026	0.71
493027	1.21
493028	0.71
493301	1.21
494001	0.87
494002	1.04
494011	0.82
494012	0.83
494016	0.73
494018	0.88
494020	0.87
494022	0.69
494023	0.78
494025	0.82
494026	0.78
494028	0.87
500001	1.86
500002	1.31
500003	1.61
500005	1.95
500007	2.03

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
500008	1.18
500011	1.59
500012	2.00
500014	1.85
500015	1.31
500016	1.41
500019	2.04
500021	1.42
500023	1.39
500024	2.58
500025	1.31
500026	1.53
500027	1.87
500028	0.85
500029	0.72
500030	1.75
500031	1.29
500033	1.59
500036	1.80
500037	1.07
500039	1.93
500041	1.53
500042	2.22
500043	1.06
500044	1.72
500045	1.73
500048	1.17
500049	2.08
500050	1.84
500051	1.97
500053	1.48
500054	1.86
500055	1.33
500057	1.81
500058	1.96
500059	1.66
500060	1.30
500061	0.75
500062	0.59
500064	0.87
500065	1.76
500068	0.76
500069	0.92
500071	1.47
500072	1.74
500073	0.98
500074	1.51
500077	1.51
500079	1.17
500080	0.82
500084	1.43
500085	1.12
500086	1.34
500088	1.94
500089	1.19
500090	0.49
500092	1.10
500094	0.59
500096	1.26
500097	0.83
500098	0.98
500101	0.85
500102	1.00
500104	1.34
500106	0.79
500107	1.21
500108	1.72
500110	1.77
500118	1.62
500119	1.22
500122	1.43
500123	0.61
500124	1.52
500125	0.99
500129	1.44
500132	1.05

Note: The median service mix for all hospitals is 1.45

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
500138	0.90
500139	1.62
500141	1.81
500146	1.69
502002	2.34
503025	0.99
503300	4.72
504002	0.75
504008	0.83
510001	1.62
510002	1.70
510004	0.77
510005	1.11
510006	1.86
510007	1.31
510008	1.52
510012	1.28
510013	1.17
510015	0.76
510016	0.73
510018	1.18
510020	0.88
510022	1.68
510023	1.56
510024	1.97
510026	1.12
510027	0.99
510028	1.04
510029	1.57
510030	1.50
510031	2.16
510033	1.48
510038	1.13
510039	1.54
510043	0.64
510046	1.05
510047	2.11
510048	0.95
510050	1.57
510053	1.03
510055	1.49
510058	1.66
510059	5.37
510060	1.13
510063	0.74
510065	0.80
510066	1.43
510067	1.52
510068	1.26
510070	2.03
510071	1.73
510072	1.04
510077	1.03
510081	0.71
510082	1.13
510084	1.27
510085	1.37
510086	0.91
511300	1.04
511301	0.58
513026	0.62
513027	0.98
513028	1.10
513030	1.04
514001	0.96
514007	1.22
514008	1.29
520002	2.63
520003	1.59
520004	2.63
520006	4.45
520007	1.27
520008	1.79
520009	1.27
520010	1.51
520011	2.38

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
520013	1.76
520014	1.82
520015	2.06
520016	3.42
520017	1.46
520018	1.52
520019	1.65
520021	2.27
520024	1.40
520025	1.38
520026	1.75
520028	2.46
520029	0.89
520030	3.47
520031	2.68
520032	1.67
520033	2.40
520034	1.80
520035	3.33
520037	2.04
520038	2.45
520039	2.16
520040	1.31
520041	2.16
520042	1.28
520044	2.12
520045	1.37
520047	1.63
520048	1.62
520049	2.96
520051	1.85
520053	1.23
520054	1.19
520057	5.86
520058	1.96
520059	1.92
520060	1.19
520062	2.43
520063	3.44
520064	1.32
520066	2.82
520068	1.13
520069	1.39
520070	1.81
520071	1.66
520074	1.21
520075	1.68
520076	2.23
520077	0.97
520078	2.01
520082	2.49
520083	1.40
520084	2.38
520087	1.74
520088	1.61
520089	4.31
520090	1.38
520091	3.18
520092	1.51
520094	1.25
520095	4.22
520096	1.92
520097	1.73
520098	1.16
520100	1.94
520101	1.13
520102	1.82
520103	1.73
520107	1.51
520109	1.73
520110	1.36
520111	2.22
520112	2.23
520113	2.82
520114	1.27
520115	1.25

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
520116	1.69
520117	1.51
520118	0.72
520120	0.77
520121	1.32
520122	0.97
520123	1.07
520124	1.31
520130	2.21
520131	1.43
520132	1.65
520134	1.16
520135	1.31
520136	1.37
520138	1.74
520139	3.15
520140	1.64
520141	1.42
520142	0.90
520144	3.38
520145	1.01
520146	1.97
520148	1.52
520149	0.80
520151	2.91
520152	1.99
520153	1.23
520154	1.95
520156	1.55
520157	1.12
520159	0.99
520160	1.73
520161	1.60
520170	2.11
520171	1.19
520173	2.77
520177	2.17
520178	1.73
523025	0.95
523300	2.03
524000	0.94
524001	0.79
524003	0.85
524017	0.35
524018	0.79
524034	0.87
524035	0.87
524038	0.98
524040	1.03
530002	1.40
530003	0.88
530004	1.06
530005	1.23
530006	1.40
530007	1.24
530008	1.34
530009	1.45
530010	1.95
530011	1.41
530012	1.58
530014	1.54
530015	1.59
530016	1.27
530017	1.64
530018	1.18
530019	1.15
530022	1.15
530023	1.07
530025	1.41
530026	1.00
530027	1.03
530029	0.75
530031	0.67
530032	1.52
532002	0.05
534003	0.87

Note: The median service mix for all hospitals is 1.45

ADDENDUM I.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
650001	1.28

ADDENDUM J.—WAGE INDEX FOR URBAN AREAS

Urban area (Constituent counties)	Wage index
0040 Abilene, TX	0.8081
Taylor, TX	
0060 Aguadilla, PR	0.4772
Aguada, PR	
Aguadilla, PR	
Moca, PR	
0080 Akron, OH	1.0011
Portage, OH	
Summit, OH	
0120 Albany, GA	0.8098
Dougherty, GA	
Lee, GA	
0160 [2] Albany-Schenectady-Troy, NY	0.8640
Albany, NY	
Montgomery, NY	
Rensselaer, NY	
Saratoga, NY	
Schenectady, NY	
Schoharie, NY	
0200 Albuquerque, NM	0.8813
Bernalillo, NM	
Sandoval, NM	
Valencia, NM	
0220 Alexandria, LA	0.8598
Rapides, LA	
0240 Allentown-Bethlehem-Easton, PA	1.0219
Carbon, PA	
Lehigh, PA	
Northampton, PA	
0280 Altoona, PA	0.9398
Blair, PA	
0320 Amarillo, TX	0.8483
Potter, TX	
Randall, TX	
0380 Anchorage, AK	1.3088
Anchorage, AK	
0440 Ann Arbor, MI	1.1127I
Lenawee, MI	
Livingston, MI	
Washtenaw, MI	
0450 Anniston, AL	0.8731
Calhoun, AL	
0460 Appleton-Oshkosh-Neenah, WI	0.8899
Calumet, WI	
Outagamie, WI	
Winnebago, WI	
0470 Arecibo, PR	0.4915
Arecibo, PR	
Camuy, PR	
Hatillo, PR	
0480 Asheville, NC	0.9016
Buncombe, NC	
Madison, NC	
0500 Athens, GA	0.8746
Clarke, GA	
Madison, GA	
Oconee, GA	
0520 [1] Atlanta, GA	1.0024
Barrow, GA	
Bartow, GA	
Carroll, GA	
Cherokee, GA	
Clayton, GA	
Cobb, GA	
Coweta, GA	
DeKalb, GA	
Douglas, GA	
Fayette, GA	
Forsyth, GA	
Fulton, GA	
Gwinnett, GA	
Henry, GA	
Newton, GA	

ADDENDUM J.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (Constituent counties)	Wage index
Paulding, GA	
Pickens, GA	
Rockdale, GA	
Spalding, GA	
Walton, GA	
0560 Atlantic-Cape May, NJ	1.0442
Atlantic, NJ	
Cape May, NJ	
0600 Augusta-Aiken, GA-SC	0.9309
Columbia, GA	
McDuffie, GA	
Richmond, GA	
Aiken, SC	
Edgefield, SC	
0640 [1] Austin-San Marcos, TX	0.8158
Bastrop, TX	
Caldwell, TX	
Hays, TX	
Travis, TX	
Williamson, TX	
0680 [2] Bakersfield, CA	0.9976
Kern, CA	
0720 [1] Baltimore, MD	0.9760
Anne Arundel, MD	
Baltimore, MD	
Baltimore City, MD	
Carroll, MD	
Harford, MD	
Howard, MD	
Queen Anne's, MD	
0733 [2] Bangor, ME	0.8538
Penobscot, ME	0.8538
0743 Barnstable-Yarmouth, MA	1.5644
Barnstable, MA	
0760 Baton Rouge, LA	0.8940
Ascension, LA	
East Baton Rouge, LA	
Livingston, LA	
West Baton Rouge, LA	
0840 Beaumont-Port Arthur, TX	0.8660
Hardin, TX	
Jefferson, TX	
Orange, TX	
0860 Bellingham, WA	1.1475
Whatcom, WA	
0870 [2] Benton Harbor, MI	0.8988
Berrien, MI	
0875 [1] Bergen-Passaic, NJ	1.1845
Bergen, NJ	
Passaic, NJ	
0880 Billings, MT	0.9220
Yellowstone, MT	
0920 Biloxi-Gulfport-Pascagoula, MS	0.8291
Hancock, MS	
Harrison, MS	
Jackson, MS	
0960 Binghamton, NY	0.9103
Broome, NY	
Tioga, NY	
1000 Birmingham, AL	0.9150
Blount, AL	
Jefferson, AL	
St. Clair, AL	
Shelby, AL	
1010 Bismarck, ND	0.8015
Burleigh, ND	
Morton, ND	
1020 Bloomington, IN	0.9041
Monroe, IN	
1040 Bloomington-Normal, IL	0.8926
McLean, IL	
1080 Boise City, ID	0.9267
Ada, ID	
Canyon, ID	
1123 [1 2] Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH (Massachusetts Hospitals)	1.0917
Bristol, MA	
Essex, MA	
Middlesex, MA	
Norfolk, MA	
Plymouth, MA	
Suffolk, MA	
Worcester, MA	
Hillsborough, NH	
Merrimack, NH	
Rockingham, NH	
Strafford, NH	
1123 [1] Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH (New Hampshire Hospitals)	1.0885
Bristol, MA	
Essex, MA	
Middlesex, MA	
Norfolk, MA	
Plymouth, MA	
Suffolk, MA	
Worcester, MA	
Hillsborough, NH	
Merrimack, NH	
Rockingham, NH	
Strafford, NH	
1125 Boulder-Longmont, CO	1.0122
Boulder, CO	
1145 Brazoria, TX	0.8895
Brazoria, TX	
1150 Bremerton, WA	1.1148
Kitsap, WA	
1240 Brownsville-Harlingen-San Benito, TX	0.8291
Cameron, TX	
1260 Bryan-College Station, TX	0.7962
Brazos, TX	
1280 [1] Buffalo-Niagara Falls, NY	0.9592
Erie, NY	
Niagara, NY	
1303 Burlington, VT	0.9612
Chittenden, VT	
Franklin, VT	
Grand Isle, VT	
1310 Caguas, PR	0.4445
Caguas, PR	
Cayey, PR	
Cidra, PR	
Gurabo, PR	
San Lorenzo, PR	
1320 Canton-Massillon, OH	0.8895
Carroll, OH	
Stark, OH	
1350 Casper, WY	0.9227
Natrona, WY	
1360 Cedar Rapids, IA	0.8888
Linn, IA	
1400 Champaign-Urbana, IL	0.8844
Champaign, IL	
1440 Charleston-North Charleston, SC	0.8931

ADDENDUM J.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (Constituent counties)	Wage index
Berkeley, SC	
Charleston, SC	
Dorchester, SC	
1480 Charleston, WV	0.9042
Kanawha, WV	
Putnam, WV	
1520 [1]Charlotte-Gastonia-Rock Hill, NC-SC	0.9568
Cabarrus, NC	
Gaston, NC	
Lincoln, NC	
Mecklenburg, NC	
Rowan, NC	
Stanly, NC	
Union, NC	
York, SC	
1540 Charlottesville, VA	1.0359
Albemarle, VA	
Charlottesville City, VA	
Fluvanna, VA	
Greene, VA	
1560 Chattanooga, TN-GA	0.9123
Catoosa, GA	
Dade, GA	
Walker, GA	
Hamilton, TN	
Marion, TN	
1580 Cheyenne, WY	0.9354
Laramie, WY	
1600 [1]Chicago, IL	1.0507
Cook, IL	
DeKalb, IL	
DuPage, IL	
Grundy, IL	
Kane, IL	
Kendall, IL	
Lake, IL	
McHenry, IL	
Will, IL	
1620 Chico-Paradise, CA	1.0231
Butte, CA	
1640 [1]Cincinnati, OH-KY-IN	0.9465
Dearborn, IN	
Ohio, IN	
Boone, KY	
Campbell, KY	
Gallatin, KY	
Grant, KY	
Kenton, KY	
Pendleton, KY	
Brown, OH	
Clermont, OH	
Hamilton, OH	
Warren, OH	
1660 Clarksville-Hopkinsville, TN-KY	0.8204
Christian, KY	
Montgomery, TN	
1680 [1]Cleveland-Lorain-Elyria, OH	0.9970
Ashtabula, OH	
Cuyahoga, OH	
Geauga, OH	
Lake, OH	
Lorain, OH	
Medina, OH	
1720 Colorado Springs, CO	0.9469
El Paso, CO	
1740 Columbia, MO	0.9678
Boone, MO	
1760 Columbia, SC	0.9368
Lexington, SC	
Richland, SC	
1800 Columbus, GA-AL	0.8573
Russell, AL	
Chattahoochee, GA	
Harris, GA	
Muscogee, GA	
1840 [1]Columbus, OH	0.9929
Delaware, OH	
Fairfield, OH	
Franklin, OH	
Licking, OH	
Madison, OH	
Pickaway, OH	
1880 Corpus Christi, TX	0.8112
Nueces, TX	
San Patricio, TX	
1900 [2]Cumberland, MD-WV (Maryland Hospitals)	0.8627
Allegany, MD	
Mineral, WV	
1900 Cumberland, MD-WV (West Virginia Hospital)	0.8407
Allegany, MD	
Mineral, WV	
1920 [1]Dallas, TX	0.9149
Collin, TX	
Dallas, TX	
Denton, TX	
Ellis, TX	
Henderson, TX	
Hunt, TX	
Kaufman, TX	
Rockwall, TX	
1950 Danville, VA	0.9121
Danville City, VA	
Pittsylvania, VA	
1960 Davenport-Moline-Rock Island, IA-IL	0.8496
Scott, IA	
Henry, IL	
Rock Island, IL	
2000 Dayton-Springfield, OH	0.9670
Clark, OH	
Greene, OH	
Miami, OH	
Montgomery, OH	
2020 Daytona Beach, FL	0.9211
Flagler, FL	
Volusia, FL	
2030 Decatur, AL	0.8302
Lawrence, AL	
Morgan, AL	
2040 Decatur, IL	0.8140
Macon, IL	
2080 [1]Denver, CO	1.0532
Adams, CO	
Arapahoe, CO	
Denver, CO	
Douglas, CO	
Jefferson, CO	
2120 Des Moines, IA	0.8576
Dallas, IA	
Polk, IA	
Warren, IA	
2160 [1]Detroit, MI	1.0601
Lapeer, MI	
Macomb, MI	
Monroe, MI	
Oakland, MI	
St. Clair, MI	
Wayne, MI	
2180 Dothan, AL	0.7827
Dale, AL	
Houston, AL	
2190 Dover, DE	0.9441
Kent, DE	
2200 Dubuque, IA	0.8292
Dubuque, IA	
2240 Duluth-Superior, MN-WI	1.0133
St. Louis, MN	
Douglas, WI	
2281 Dutchess County, NY	0.9860
Dutchess, NY	
2290 Eau Claire, WI	0.8755
Chippewa, WI	
Eau Claire, WI	
2320 El Paso, TX	0.8978
El Paso, TX	
2330 Elkhart-Goshen, IN	0.9168
Elkhart, IN	
2335 [2]Elmira, NY	0.8640
Chemung, NY	
2340 Enid, OK	0.8050
Garfield, OK	
2360 Erie, PA	0.9343
Erie, PA	
2400 Eugene-Springfield, OR	1.1288
Lane, OR	
2440 Evansville-Henderson, IN-KY	0.8505
Posey, IN	
Vanderburgh, IN	
Warrick, IN	
Henderson, KY	
2520 Fargo-Moorhead, ND-MN (North Dakota Hospitals)	0.7905
Clay, MN	
Cass, ND	
2520 [2]Fargo-Moorhead, ND-MN (Minnesota Hospitals)	0.8665
Clay, MN	
Cass, ND	
2560 Fayetteville, NC	0.8460
Cumberland, NC	
2580 Fayetteville-Springdale-Rogers, AR	0.8686
Benton, AR	
Washington, AR	
2620 Flagstaff, AZ-UT	0.9602
Coconino, AZ	
Kane, UT	
2640 Flint, MI	1.1106
Genesee, MI	
2650 Florence, AL	0.7740
Colbert, AL	
Lauderdale, AL	
2655 Florence, SC	0.8368
Florence, SC	
2670 Fort Collins-Loveland, CO	1.0383
Larimer, CO	
2680 [1]Ft. Lauderdale, FL	1.0534
Broward, FL	
2700 Fort Myers-Cape Coral, FL	0.9017
Lee, FL	
2710 Fort Pierce-Port St. Lucie, FL	0.9847
Martin, FL	
St. Lucie, FL	
2720 Fort Smith, AR-OK	0.7687
Crawford, AR	
Sebastian, AR	
Sequoyah, OK	
2750 [2]Fort Walton Beach, FL	0.8947
Okaloosa, FL	
2760 Fort Wayne, IN	0.8896
Adams, IN	
Allen, IN	
De Kalb, IN	
Huntington, IN	
Wells, IN	
Whitley, IN	
2800 [1]Forth Worth-Arlington, TX	0.9192
Hood, TX	
Johnson, TX	
Parker, TX	
Tarrant, TX	
2840 Fresno, CA	1.0491
Fresno, CA	
Madera, CA	

ADDENDUM J.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (Constituent counties)	Wage index
2880 Gadsden, AL	0.8854
Etowah, AL	
2900 Gainesville, FL	0.9542
Alachua, FL	
2920 Galveston-Texas City, TX	0.9549
Galveston, TX	
2960 Gary, IN	0.9542
Lake, IN	
Porter, IN	
2975 [2] Glens Falls, NY	0.8640
Warren, NY	
Washington, NY	
2980 Goldsboro, NC	0.8523
Wayne, NC	
2985 Grand Forks, ND-MN	0.8996
Polk, MN	
Grand Forks, ND	
2995 Grand Junction, CO	0.9110
Mesa, CO	
3000 [1] Grand Rapids-Muskegon-Holland, MI	1.0018
Allegan, MI	
Kent, MI	
Muskegon, MI	
Ottawa, MI	
3040 Great Falls, MT	0.9362
Cascade, MT	
3060 Greeley, CO	0.9856
Weld, CO	
3080 Green Bay, WI	0.9323
Brown, WI	
3120 [1] Greensboro-Winston-Salem-High Point, NC	0.9418
Alamance, NC	
Davidson, NC	
Davie, NC	
Forsyth, NC	
Guilford, NC	
Randolph, NC	
Stokes, NC	
Yadkin, NC	
3150 Greenville, NC	0.9034
Pitt, NC	
3160 Greenville-Spartanburg-Anderson, SC	0.9318
Anderson, SC	
Cherokee, SC	
Greenville, SC	
Pickens, SC	
Spartanburg, SC	
3180 Hagerstown, MD	1.0268
Washington, MD	
3200 Hamilton-Middletown, OH	0.9292
Butler, OH	
3240 Harrisburg-Lebanon-Carlisle, PA	0.9572
Cumberland, PA	
Dauphin, PA	
Lebanon, PA	
Perry, PA	
3283 [1 2] Hartford, CT	1.2175
Hartford, CT	
Litchfield, CT	
Middlesex, CT	
Tolland, CT	
3285 [2] Hattiesburg, MS	0.7359
Forrest, MS	
Lamar, MS	
3290 Hickory-Morganton-Lenoir, NC	0.8687
Alexander, NC	
Burke, NC	
Caldwell, NC	
Catawba, NC	
3320 Honolulu, HI	1.1628
Honolulu, HI	
3350 Houma, LA	0.8266
Lafourche, LA	
Terrebonne, LA	
3360 [1] Houston, TX	1.0017
Chambers, TX	
Fort Bend, TX	
Harris, TX	
Liberty, TX	
Montgomery, TX	
Waller, TX	
3400 Huntington-Ashland, WV-KY-OH	0.9728
Boyd, KY	
Carter, KY	
Greenup, KY	
Lawrence, OH	
Cabell, WV	
Wayne, WV	
3440 Huntsville, AL	0.8428
Limestone, AL	
Madison, AL	
3480 [1] Indianapolis, IN	0.9901
Boone, IN	
Hamilton, IN	
Hancock, IN	
Hendricks, IN	
Johnson, IN	
Madison, IN	
Marion, IN	
Morgan, IN	
Shelby, IN	
3500 Iowa City, IA	0.9561
Johnson, IA	
3520 Jackson, MI	0.9302
Jackson, MI	
3560 Jackson, MS	0.8279
Hinds, MS	
Madison, MS	
Rankin, MS	
3580 Jackson, TN	0.8632
Madison, TN	
Chester, TN	
3600 [1 2] Jacksonville, FL	0.8947
Clay, FL	
Duval, FL	
Nassau, FL	
St. Johns, FL	
3605 [2] Jacksonville, NC	0.8162
Onslow, NC	
3610 [2] Jamestown, NY	0.8640
Chautauqua, NY	
3620 Janesville-Beloit, WI	0.9128
Rock, WI	
3640 Jersey City, NJ	1.1372
Hudson, NJ	
3660 Johnson City-Kingsport-Bristol, TN-VA	0.8847
Carter, TN	
Hawkins, TN	
Sullivan, TN	
Unicoi, TN	
Washington, TN	
Bristol City, VA	
Scott, VA	
Washington, VA	
3680 Johnstown, PA	0.8671
Cambria, PA	
Somerset, PA	
3700 Jonesboro, AR	0.7643
Craighead, AR	
3710 Joplin, MO	0.7933
Jasper, MO	
Newton, MO	
3720 Kalamazoo-Battlecreek, MI	1.2009
Calhoun, MI	
Kalamazoo, MI	
Van Buren, MI	
3740 Kankakee, IL	0.9175
Kankakee, IL	
3760 [1] Kansas City, KS-MO	0.9672
Johnson, KS	
Leavenworth, KS	
Miami, KS	
Wyandotte, KS	
Cass, MO	
Clay, MO	
Clinton, MO	
Jackson, MO	
Lafayette, MO	
Platte, MO	
Ray, MO	
3800 Kenosha, WI	0.9206
Kenosha, WI	
3810 Killeen-Temple, TX	1.0180
Bell, TX	
Coryell, TX	
3840 Knoxville, TN	0.8569
Anderson, TN	
Blount, TN	
Knox, TN	
Loudon, TN	
Sevier, TN	
Union, TN	
3850 Kokomo, IN	0.9350
Howard, IN	
Tipton, IN	
3870 La Crosse, WI-MN	0.8989
Houston, MN	
La Crosse, WI	
3880 Lafayette, LA	0.8363
Acadia, LA	
Lafayette, LA	
St. Landry, LA	
St. Martin, LA	
3920 Lafayette, IN	0.8984
Clinton, IN	
Tippecanoe, IN	
3960 Lake Charles, LA	0.7738
Calcasieu, LA	
3980 Lakeland-Winter Haven, FL	0.8947
Polk, FL	
4000 Lancaster, PA	0.9646
Lancaster, PA	
4040 Lansing-East Lansing, MI	1.0130
Clinton, MI	
Eaton, MI	
Ingham, MI	
4080 [2] Laredo, TX	0.7404
Webb, TX	
4100 Las Cruces, NM	0.9045
Dona Ana, NM	
4120 [1] Las Vegas, NV-AZ	1.1349
Mohave, AZ	
Clark, NV	
Nye, NV	
4150 Lawrence, KS	0.8728
Douglas, KS	
4200 Lawton, OK	0.8770
Comanche, OK	
4243 Lewiston-Auburn, ME	0.9226
Androscoggin, ME	
4280 Lexington, KY	0.8579
Bourbon, KY	
Clark, KY	
Fayette, KY	
Jessamine, KY	
Madison, KY	
Scott, KY	
Woodford, KY	
4320 Lima, OH	0.8885
Allen, OH	
Auglaize, OH	

ADDENDUM J.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (Constituent counties)	Wage index
4360 Lincoln, NE	0.9082
Lancaster, NE	
4400 Little Rock-North Little Rock, AR	0.8598
Faulkner, AR	
Lonoke, AR	
Pulaski, AR	
Saline, AR	
4420 Longview-Marshall, TX	0.8583
Gregg, TX	
Harrison, TX	
Upshur, TX	
4480 [1] Los Angeles-Long Beach, CA	1.2124
Los Angeles, CA	
4520 Louisville, KY-IN	0.9212
Clark, IN	
Floyd, IN	
Harrison, IN	
Scott, IN	
Bullitt, KY	
Jefferson, KY	
Oldham, KY	
4600 Lubbock, TX	0.8460
Lubbock, TX	
4640 Lynchburg, VA	0.8680
Amherst, VA	
Bedford, VA	
Bedford City, VA	
Campbell, VA	
Lynchburg City, VA	
4680 Macon, GA	0.9109
Bibb, GA	
Houston, GA	
Jones, GA	
Peach, GA	
Twiggs, GA	
4720 Madison, WI	1.0103
Dane, WI	
4800 Mansfield, OH	0.8606
Crawford, OH	
Richland, OH	
4840 Mayaguez, PR	0.4360
Anasco, PR	
Cabo Rojo, PR	
Hormigueros, PR	
Mayaguez, PR	
Sabana Grande, PR	
San German, PR	
4880 McAllen-Edinburg-Mission, TX	0.8541
Hidalgo, TX	
4890 Medford-Ashland, OR	1.0109
Jackson, OR	
4900 Melbourne-Titusville-Palm Bay, FL	0.9289
Brevard, Fl	
4920 [1] Memphis, TN-AR-MS	0.8423
Crittenden, AR	
DeSoto, MS	
Fayette, TN	
Shelby, TN	
Tipton, TN	
4940 Merced, CA	1.0304
Merced, CA	
5000 [1] Miami, FL	0.9427
Dade, FL	
5015 [1] Middlesex-Somerset-Hunterdon, NJ	1.0871
Hunterdon, NJ	
Middlesex, NJ	
Somerset, NJ	
5080 [1] Milwaukee-Waukesha, WI	0.9470
Milwaukee, WI	
Ozaukee, WI	
Washington, WI	
Waukesha, WI	
5120 [1] Minneapolis-St. Paul, MN-WI	1.0956
Anoka, MN	
Carver, MN	
Chisago, MN	
Dakota, MN	
Hennepin, MN	
Isanti, MN	
Ramsey, MN	
Scott, MN	
Sherburne, MN	
Washington, MN	
Wright, MN	
Pierce, WI	
St. Croix, WI	
5160 Mobile, AL	0.7942
Baldwin, AL	
Mobile, AL	
5170 Modesto, CA	1.0406
Stanislaus, CA	
5190 [1] Monmouth-Ocean, NJ	1.1285
Monmouth, NJ	
Ocean, NJ	
5200 Monroe, LA	0.8288
Ouachita, LA	
5240 Montgomery, AL	0.7919
Autauga, AL	
Elmore, AL	
Montgomery, AL	
5280 Muncie, IN	0.9493
Delaware, IN	
5330 [2] Myrtle Beach, SC	0.8110
Horry, SC	
5345 Naples, FL	1.0205
Collier, FL	
5360 [1] Nashville, TN	0.9336
Cheatham, TN	
Davidson, TN	
Dickson, TN	
Robertson, TN	
Rutherford TN	
Sumner, TN	
Williamson, TN	
Wilson, TN	
5380 [1] Nassau-Suffolk, NY	1.3123
Nassau, NY	
Suffolk, NY	
5483 [1 2] New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	1.2175
Fairfield, CT	
New Haven, CT	
5523 [2] New London-Norwich, CT	1.2175
New London, CT	
5560 [1] New Orleans, LA	0.9397
Jefferson, LA	
Orleans, LA	
Plaquemines, LA	
St. Bernard, LA	
St. Charles, LA	
St. James, LA	
St. John The Baptist, LA	
St. Tammany, LA	
5600 [1] New York, NY	1.4537
Bronx, NY	
Kings, NY	
New York, NY	
Putnam, NY	
Queens, NY	
Richmond, NY	
Rockland, NY	
Westchester, NY	
5640 [1] Newark, NJ	1.0899
Essex, NJ	
Morris, NJ	
Sussex, NJ	
Union, NJ	
Warren, NJ	
5660 Newburgh, NY–PA	1.1226
Orange, NY	
Pike, PA	
5720 [1] Norfolk-Virginia Beach-Newport News, VA–NC	0.8235
Currituck, NC	
Chesapeake City, VA	
Gloucester, VA	
Hampton City, VA	
Isle of Wight, VA	
James City, VA	
Mathews, VA	
Newport News City, VA	
Norfolk City, VA	
Poquoson City, VA	
Portsmouth City, VA	
Suffolk City, VA	
Virginia Beach City, VA	
Williamsburg City, VA	
York, VA	
5775 [1] Oakland, CA	1.5309
Alameda, CA	
Contra Costa, CA	
5790 Ocala, FL	0.9229
Marion, FL	
5800 Odessa-Midland, TX	0.7773
Ector, TX	
Midland, TX	
5880 [1] Oklahoma City, OK	0.8764
Canadian, OK	
Cleveland, OK	
Logan, OK	
McClain, OK	
Oklahoma, OK	
Pottawatomie, OK	
5910 Olympia, WA	1.1605
Thurston, WA	
5920 Omaha, NE–IA	0.9938
Pottawattamie, IA	
Cass, NE	
Douglas, NE	
Sarpy, NE	
Washington, NE	
5945 [1] Orange County, CA	1.1153
Orange, CA	
5960 [1] Orlando, FL	0.9933
Lake, FL	
Orange, FL	
Osceola, FL	
Seminole, FL	
5990 [2] Owensboro, KY	0.7902
Daviess, KY	
6015 [2] Panama City, FL	0.8947
Bay, FL	
6020 Parkersburg-Marietta, WV–OH (West Virginia Hospitals)	0.8118
Washington, OH	
Wood, WV	
6020 [2] Parkersburg-Marietta, WV–OH (Ohio Hospitals)	0.8576
Washington, OH	
Wood, WV	
6080 [2] Pensacola, FL	0.8947
Escambia, FL	
Santa Rosa, FL	
6120 Peoria-Pekin, IL	0.8157
Peoria, IL	
Tazewell, IL	
Woodford, IL	
6160 [1] Philadelphia, PA–NJ	1.1427
Burlington, NJ	
Camden, NJ	
Gloucester, NJ	
Salem, NJ	
Bucks, PA	
Chester, PA	

ADDENDUM J.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (Constituent counties)	Wage index
Delaware, PA	
Montgomery, PA	
Philadelphia, PA	
6200 [1] Phoenix-Mesa, AZ	0.9759
Maricopa, AZ	
Pinal, AZ	
6240 Pine Bluff, AR	0.8003
Jefferson, AR	
6280 [1] Pittsburgh, PA	0.9896
Allegheny, PA	
Beaver, PA	
Butler, PA	
Fayette, PA	
Washington, PA	
Westmoreland, PA	
6323 [2] Pittsfield, MA	1.0917
Berkshire, MA	
6340 Pocatello, ID	0.8760
Bannock, ID	
6360 Ponce, PR	0.4740
Guayanilla, PR	
Juana Diaz, PR	
Penuelas, PR	
Ponce, PR	
Villalba, PR	
Yauco, PR	
6403 Portland, ME	0.9537
Cumberland, ME	
Sagadahoc, ME	
York, ME	
6440 [1] Portland-Vancouver, OR–WA	1.1274
Clackamas, OR	
Columbia, OR	
Multnomah, OR	
Washington, OR	
Yamhill, OR	
Clark, WA	
6483 [1] Providence-Warwick-Pawtucket, RI	1.0888
Bristol, RI	
Kent, RI	
Newport, RI	
Providence, RI	
Washington, RI	
6520 Provo-Orem, UT	0.9910
Utah, UT	
6560 Pueblo, CO	0.8785
Pueblo, CO	
6580 Punta Gorda, FL	0.8994
Charlotte, FL	
6600 Racine, WI	0.9207
Racine, WI	
6640 [1] Raleigh-Durham-Chapel Hill, NC	0.9909
Chatham, NC	
Durham, NC	
Franklin, NC	
Johnston, NC	
Orange, NC	
Wake, NC	
6660 Rapid City, SD	0.8277
Pennington, SD	
6680 Reading, PA	0.9282
Berks, PA	
6690 Redding, CA	1.2017
Shasta, CA	
6720 Reno, NV	1.0169
Washoe, NV	
6740 [2] Richland-Kennewick-Pasco, WA	1.0577
Benton, WA	
Franklin, WA	
6760 Richmond-Petersburg, VA	0.9257
Charles City County, VA	
Chesterfield, VA	
Colonial Heights City, VA	
Dinwiddie, VA	
Goochland, VA	

ADDENDUM J.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (Constituent counties)	Wage index
Hanover, VA	
Henrico, VA	
Hopewell City, VA	
New Kent, VA	
Petersburg City, VA	
Powhatan, VA	
Prince George, VA	
Richmond City, VA	
6780 [1] Riverside-San Bernardino, CA	1.0151
Riverside, CA	
San Bernardino, CA	
6800 Roanoke, VA	0.8581
Botetourt, VA	
Roanoke, VA	
Roanoke City, VA	
Salem City, VA	
6820 Rochester, MN	1.1797
Olmsted, MN	
6840 [1] Rochester, NY	0.9678
Genesee, NY	
Livingston, NY	
Monroe, NY	
Ontario, NY	
Orleans, NY	
Wayne, NY	
6880 Rockford, IL	0.8703
Boone, IL	
Ogle, IL	
Winnebago, IL	
6895 Rocky Mount, NC	0.8214
Edgecombe, NC	
Nash, NC	
6920 [1] Sacramento, CA	1.1952
El Dorado, CA	
Placer, CA	
Sacramento, CA	
6960 Saginaw-Bay City-Midland, MI	0.9567
Bay, MI	
Midland, MI	
Saginaw, MI	
6980 St. Cloud, MN	0.9667
Benton, MN	
Stearns, MN	
7000 St. Joseph, MO	0.9972
Andrew, MO	
Buchanan, MO	
7040 [1] St. Louis, MO-IL	0.9063
Clinton, IL	
Jersey, IL	
Madison, IL	
Monroe, IL	
St. Clair, IL	
Franklin, MO	
Jefferson, MO	
Lincoln, MO	
St. Charles, MO	
St. Louis, MO	
St. Louis City, MO	
Warren, MO	
7080 Salem, OR	0.9987
Marion, OR	
Polk, OR	
7120 Salinas, CA	1.5270
Monterey, CA	
7160 [1] Salt Lake City-Ogden, UT	0.9458
Davis, UT	
Salt Lake, UT	
Weber, UT	
7200 San Angelo, TX	0.7512
Tom Green, TX	
7240 [1] San Antonio, TX	0.7744
Bexar, TX	
Comal, TX	
Guadalupe, TX	
Wilson, TX	

ADDENDUM J.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (Constituent counties)	Wage index
7320 [1] San Diego, CA	1.2388
San Diego, CA	
7360 [1] San Francisco, CA	1.362
Marin, CA	
San Francisco, CA	
San Mateo, CA	
7400 [1] San Jose, CA	1.3783
Santa Clara, CA	
7440 [1] San Juan-Bayamon, PR	0.4521
Aguas Buenas, PR	
Barceloneta, PR	
Bayamon, PR	
Canovanas, PR	
Carolina, PR	
Catano, PR	
Ceiba, PR	
Comerio, PR	
Corozal, PR	
Dorado, PR	
Fajardo, PR	
Florida, PR	
Guaynabo, PR	
Humacao, PR	
Juncos, PR	
Los Piedras, PR	
Loiza, PR	
Luguillo, PR	
Manati, PR	
Morovis, PR	
Naguabo, PR	
Naranjito, PR	
Rio Grande, PR	
San Juan, PR	
Toa Alta, PR	
Toa Baja, PR	
Trujillo Alto, PR	
Vega Alta, PR	
Vega Baja, PR	
Yabucoa, PR	
7460 San Luis Obispo-Atascadero-Paso Robles, CA	1.0825
San Luis Obispo, CA	
7480 Santa Barbara-Santa Maria-Lompoc, CA	1.1233
Santa Barbara, CA	
7485 Santa Cruz-Watsonville, CA	1.4099
Santa Cruz, CA	
7490 Santa Fe, NM	0.9525
Los Alamos, NM	
Santa Fe, NM	
7500 Santa Rosa, CA	1.3167
Sonoma, CA	
7510 Sarasota-Bradenton, FL	0.9567
Manatee, FL	
Sarasota, FL	
7520 Savannah, GA	0.8776
Bryan, GA	
Chatham, GA	
Effingham, GA	
7560 [2] Scranton—Wilkes-Barre—Hazleton, PA	.8615
Columbia, PA	
Lackawanna, PA	
Luzerne, PA	
Wyoming, PA	
7600 [1] Seattle-Bellevue-Everett, WA	1.1634
Island, WA	
King, WA	
Snohomish, WA	
7610 Sharon, PA	0.8948
Mercer, PA	
7620 [2] Sheboygan, WI	0.8557
Sheboygan, WI	
7640 Sherman-Denison, TX	0.8229
Grayson, TX	

ADDENDUM J.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (Constituent counties)	Wage index
7680 Shreveport-Bossier City, LA	0.9436
Bossier, LA	
Caddo, LA	
Webster, LA	
7720 Sioux City, IA-NE	0.8530
Woodbury, IA	
Dakota, NE	
7760 Sioux Falls, SD	0.8988
Lincoln, SD	
Minnehaha, SD	
7800 South Bend, IN	0.9939
St. Joseph, IN	
7840 Spokane, WA	1.1020
Spokane, WA	
7880 Springfield, IL	0.8793
Menard, IL	
Sangamon, IL	
7920 Springfield, MO	0.8151
Christian, MO	
Greene, MO	
Webster, MO	
g1 Springfield, MA	1.0917
8003 Hampden, MA.	
Hampshire, MA	
8050 State College, PA	0.9528
Centre, PA	
8080 [2] Steubenville-Weirton, OH-WV (Ohio Hospitals)	0.8576
Jefferson, OH	
Brooke, WV	
Hancock, WV	
8080 Steubenville-Weirton, OH-WV (West Virginia Hospitals)	0.8476
Jefferson, OH	
Brooke, WV	
Hancock, WV	
8120 Stockton-Lodi, CA	1.1157
San Joaquin, CA	
8140 Sumter, SC	0.8195
Sumter, SC	
8160 Syracuse, NY	0.9410
Cayuga, NY	
Madison, NY	
Onondaga, NY	
Oswego, NY	
8200 [2] Tacoma, WA	1.0577
Pierce, WA	
8240 [2] Tallahassee, FL	0.8947
Gadsden, FL	
Leon, FL	
8280 [1] Tampa-St. Petersburg-Clearwater, FL	0.9179
Hernando, FL	
Hillsborough, FL	
Pasco, FL	
Pinellas, FL	
8320 Terre Haute, IN	0.9063
Clay, IN	
Vermillion, IN	
Vigo, IN	
8360 Texarkana, AR-Texarkana, TX	0.7538
Miller, AR	
Bowie, TX	
8400 Toledo, OH	1.0132
Fulton, OH	
Lucas, OH	
Wood, OH	
8440 Topeka, KS	0.9894
Shawnee, KS	
8480 Trenton, NJ	1.0399
Mercer, NJ	
8520 Tucson, AZ	0.9104
Pima, AZ	
8560 Tulsa, OK	0.8520
Creek, OK	
Osage, OK	
Rogers, OK	
Tulsa, OK	
Wagoner, OK	
8600 Tuscaloosa, AL	0.7706
Tuscaloosa, AL	
8640 Tyler, TX	0.8792
Smith, TX	
8680 [2] Utica-Rome, NY	0.8640
Herkimer, NY	
Oneida, NY	
8720 Vallejo-Fairfield-Napa, CA	1.3458
Napa, CA	
Solano, CA	
8735 Ventura, CA	1.0764
Ventura, CA	
8750 Victoria, TX	0.8451
Victoria, TX	
8760 Vineland-Millville-Bridgeton, NJ	1.0460
Cumberland, NJ	
8780 Visalia-Tulare-Porterville, CA	1.0168
Tulare, CA	
8800 Waco, TX	0.8027
McLennan, TX	
8840 [1] Washington, DC-MD-VA-WV	1.0863
District of Columbia, DC	
Calvert, MD	
Charles, MD	
Frederick, MD	
Montgomery, MD	
Prince Georges, MD	
Alexandria City, VA	
Arlington, VA	
Clarke, VA	
Culpeper, VA	
Fairfax, VA	
Fairfax City, VA	
Falls Church City, VA	
Fauquier, VA	
Fredericksburg City, VA	
King George, VA	
Loudoun, VA	
Manassas City, VA	
Manassas Park City, VA	
Prince William, VA	
Spotsylvania, VA	
Stafford, VA	
Warren, VA	
Berkeley, WV	
Jefferson, WV	
8920 Waterloo-Cedar Falls, IA	0.8402
Black Hawk, IA	
8940 Wausau, WI	0.9814
Marathon, WI	
8960 West Palm Beach-Boca Raton, FL	1.0288
Palm Beach, FL	
9000 [2] Wheeling, WV-OH (West Virginia Hospitals)	0.7938
Belmont, OH	
Marshall, WV	
Ohio, WV	
9000 [2] Wheeling, WV-OH (Ohio Hospitals)	0.8576
Belmont, OH	
Marshall, WV	
Ohio, WV	
9040 Wichita, KS	0.8990
Butler, KS	
Harvey, KS	
Sedgwick, KS	
9080 Wichita Falls, TX	0.7864
Archer, TX	
Wichita, TX	
9140 [2] Williamsport, PA	0.8615
Lycoming, PA	
9160 Wilmington-Newark, DE-MD	1.1968
New Castle, DE	
Cecil, MD	
9200 Wilmington, NC	0.9427
New Hanover, NC	
Brunswick, NC	
9260 [2] Yakima, WA	1.0577
Yakima, WA	
9270 Yolo, CA	1.0702
Yolo, CA	
9280 York, PA	0.9509
York, PA	
9320 Youngstown-Warren, OH	0.9897
Columbiana, OH	
Mahoning, OH	
Trumbull, OH	
9340 Yuba City, CA	1.0957
Sutter, CA	
Yuba, CA	
9360 Yuma, AZ	1.0143
Yuma, AZ	

[1] Large Urban Area
[2] Hospitals geographically located in the area are assigned the statewide rural wage index for FY 1999.

ADDENDUM K.—WAGE INDEX FOR RURAL AREAS

Nonurban area	Wage index
Alabama	0.7385
Alaska	1.2534
Arizona	0.8082
Arkansas	0.7274
California	0.9976
Colorado	0.8454
Connecticut	1.2175
Delaware	0.8590
Florida	0.8947
Georgia	0.7933
Hawaii	1.1011
Idaho	0.8548
Illinois	0.7985
Indiana	0.8429
Iowa	0.7846
Kansas	0.7334
Kentucky	0.7902
Louisiana	0.7517
Maine	0.8538
Maryland	0.8627
Massachusetts	1.0917
Michigan	0.8988
Minnesota	0.8665
Mississippi	0.7359
Missouri	0.7510
Montana	0.8645
Nebraska	0.7683
Nevada	0.9267
New Hampshire	1.0324
New Jersey	(1)
New Mexico	0.7927
New York	0.8640
North Carolina	0.8162
North Dakota	0.7471
Ohio	0.8576
Oklahoma	0.7207
Oregon	0.9957
Pennsylvania	0.8615
Puerto Rico	0.4083
Rhode Island	(1)
South Carolina	0.8110
South Dakota	0.7564
Tennessee	0.7483
Texas	0.7404

ADDENDUM K.—WAGE INDEX FOR RURAL AREAS—Continued

Nonurban area	Wage index
Utah	0.8851
Vermont	0.9489
Virginia	0.7890
Washington	1.0577
West Virginia	0.7938
Wisconsin	0.8557
Wyoming	0.8763

[1] All counties within the State are classified as urban.

ADDENDUM L.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED

Area	Wage index
Abilene, TX	0.8081
Albany, GA	0.7933
Albuquerque, NM	0.8813
Alexandria, LA	0.8598
Allentown-Bethlehem-Easton, PA	1.0219
Amarillo, TX	0.8483
Anchorage, AK	1.3088
Asheville, NC	0.9016
Atlanta, GA	1.0024
Augusta-Aiken, GA–SC	0.9309
Baltimore, MD	0.9760
Barnstable-Yarmouth, MA	1.4646
Baton Rouge, LA	0.8940
Benton Harbor, MI	0.8988
Bergen-Passaic, NJ	1.1845
Billings, MT	0.9220
Binghamton, NY	0.8989
Birmingham, AL	0.9150
Bismarck, ND	0.7838
Boise City, ID	0.9267
Boston-Worcester-Lawrence-Lowell-Brockton, MA–NH	1.0885
Brazoria, TX	0.8895
Bryan-College Station, TX	0.7962
Buffalo-Niagara Falls, NY	0.9592
Burlington, VT	0.9612
Caguas, PR	0.4445
Canton-Massillon, OH	0.8895
Casper, WY	0.9227
Champaign-Urbana, IL	0.8844
Charleston-North Charleston, SC	0.8931
Charleston, WV	0.8819
Charlotte-Gastonia-Rock Hill, NC–SC	0.9568
Charlottesville, VA	0.9803
Chattanooga, TN–GA	0.8885
Chicago, IL	1.0507
Cincinnati, OH–KY–IN	0.9465
Clarksville-Hopkinsville, TN–KY	0.8204
Cleveland-Lorain-Elyria, OH	0.9970
Columbia, MO	0.9331
Columbus, GA–AL	0.8573
Columbus, OH	0.9929
Corpus Christi, TX	0.8112
Dallas, TX	0.9149
Danville, VA	0.8779
Davenport-Moline-Rock Island, IA–IL	0.8496
Dayton-Springfield, OH	0.9670
Denver, CO	1.0532
Des Moines, IA	0.8576
Duluth-Superior, MN–WI	1.0133
Dutchess County, NY	0.9860
Elkhart-Goshen, IN	0.9168
Eugene-Springfield, OR	1.1141
Evansville-Henderson, IN–KY	0.8505
Fargo-Moorhead, ND–MN (Minnesota Hospital)	0.8665

ADDENDUM L.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area	Wage index
Fargo-Moorhead, ND–MN (South Dakota Hospital)	0.7905
Fayetteville, NC	0.8460
Flagstaff, AZ–UT	0.9602
Flint, MI	1.1106
Fort Collins-Loveland, CO	1.0383
Ft. Lauderdale, FL	1.0534
Fort Pierce-Port St. Lucie, FL	0.9847
Fort Smith, AR–OK	0.7582
Fort Walton Beach, FL	0.8694
Forth Worth-Arlington, TX	0.9192
Gadsden, AL	0.8854
Gainesville, FL	0.9542
Goldsboro, NC	0.8366
Grand Forks, ND–MN	0.8996
Grand Junction, CO	0.9110
Grand Rapids-Muskegon-Holland, MI	0.9908
Great Falls, MT	0.9362
Greeley, CO	0.9663
Green Bay, WI	0.9323
Greenville, NC	0.8844
Greenville-Spartanburg-Anderson, SC	0.9318
Harrisburg-Lebanon-Carlisle, PA	0.9572
Hartford, CT	1.1152
Hattiesburg, MS	0.7359
Hickory-Morganton-Lenoir, NC	0.8687
Honolulu, HI	1.1628
Houston, TX	1.0017
Huntington-Ashland, WV–KY–OH	0.9353
Huntsville, AL	0.8269
Indianapolis, IN	0.9901
Iowa City, IA	0.9441
Jackson, MS	0.8279
Jackson, TN	0.8632
Jacksonville, FL	0.8915
Johnson City-Kingsport-Bristol, TN–VA	0.8847
Jonesboro, AR	0.7643
Joplin, MO	0.7710
Kalamazoo-Battlecreek, MI	1.1713
Kansas City, KS–MO	0.9672
Knoxville, TN	0.8569
Lafayette, LA	0.8363
Lansing-East Lansing, MI	1.0025
Las Cruces, NM	0.9045
Las Vegas, NV–AZ	1.1349
Lexington, KY	0.8579
Lima, OH	0.8715
Lincoln, NE	0.8900
Little Rock-North Little Rock, AR	0.8598
Los Angeles-Long Beach, CA	1.2124
Louisville, KY–IN	0.9212
Macon, GA	0.8886
Madison, WI	1.0103
Mansfield, OH	0.8606
Memphis, TN–AR–MS	0.8423
Merced, CA	1.0304
Milwaukee-Waukesha, WI	0.9289
Minneapolis-St. Paul, MN–WI	1.0956
Modesto, CA	1.0406
Monroe, LA	0.8148
Montgomery, AL	0.7919
Myrtle Beach, SC	0.8162
Nashville, TN	0.9336
New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	1.2175
New London-Norwich, CT	1.1738
New Orleans, LA	0.9397
New York, NY	1.4537
Newark, NJ	1.0899
Newburgh, NY–PA	1.1356
Oakland, CA	1.5309

ADDENDUM L.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area	Wage index
Odessa-Midland, TX	0.7773
Oklahoma City, OK	0.8764
Omaha, NE–IA	0.9938
Orange County, CA	1.1153
Orlando, FL	0.9933
Peoria-Pekin, IL	0.8157
Philadelphia, PA–NJ	1.1427
Pittsburgh, PA	0.9740
Pocatello, ID (Idaho Hospital)	0.8760
Pocatello, ID (Wyoming Hospitals)	0.8763
Portland, ME	0.9537
Portland-Vancouver, OR–WA	1.1274
Provo-Orem, UT	0.9910
Raleigh-Durham-Chapel Hill, NC	0.9909
Rapid City, SD	0.8277
Reno, NV	1.0169
Rochester, MN	1.1797
Rockford, IL	0.8703
Sacramento, CA	1.1952
Saginaw-Bay City-Midland, MI	0.9567
St. Cloud, MN	0.9667
St. Louis, MO–IL	0.9063
Salt Lake City-Ogden, UT	0.9458
San Diego, CA	1.2388
Santa Fe, NM	0.9414
Santa Rosa, CA	1.3003
Seattle-Bellevue-Everett, WA	1.1634
Sharon, PA	0.8835
Sherman-Denison, TX	0.8061
Sioux City, IA–NE	0.8530
Sioux Falls, SD	0.8885
South Bend, IN	0.9939
Spokane, WA	1.0819
Springfield, IL	0.8793
Springfield, MO	0.8151
State College, PA	0.8845
Syracuse, NY	0.9410
Tallahassee, FL	0.8566
Tampa-St. Petersburg-Clearwater, FL	0.9179
Texarkana, AR–Texarkana, TX	0.7538
Topeka, KS	0.9667
Tucson, AZ	0.9104
Tulsa, OK	0.8418
Tuscaloosa, AL	0.7706
Tyler, TX	0.8792
Vallejo-Fairfield-Napa, CA	1.3458
Victoria, TX	0.8451
Washington, DC–MD–VA–WV	1.0863
Waterloo-Cedar Falls, IA	0.8402
Wausau, WI	0.9501
Wichita, KS	0.8853
Wichita Falls, TX	0.7695
Rural Alabama	0.7385
Rural Illinois	0.7985
Rural Louisiana	0.7517
Rural Massachusetts	1.0481
Rural Michigan	0.8988
Rural Minnesota	0.8665
Rural Missouri	0.7510
Rural Nevada	0.8855
Rural New Mexico	0.7927
Rural Oregon	0.9957
Rural Washington	1.0577
Rural Wyoming	0.8763

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